

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

It #8F11m#0397 2/13/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01885

1. DECEASED-NAME (Type or Print) Mildred Jane Ambrose			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> P <input type="checkbox"/> M		
3. SEX Female			4. RACE White		5. DATE OF BIRTH Nov. 22, 1927
6. AGE (In years last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) West Va.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.			13b. COUNTY Mineral		13c. CITY OR TOWN Ridgeley
14. FATHER'S NAME First Harvey W. Middle Willison Last 			15. MOTHER'S MAIDEN NAME First Susan Middle Pyles Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 		17. INFORMANT Sister Mrs. Lawrence Alkire, Fort Ashby, W. Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis of Lungs, Bilateral DUE TO, OR AS A CONSEQUENCE OF (b) Coma DUE TO, OR AS A CONSEQUENCE OF (c) Barbiturate Poisoning					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 12 days 12 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Alcoholism; Portal Cirrhosis					
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 		21b. TIME OF INJURY Month, Day, Year Jan. 28 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) Took barbiturates while under influence of alcohol.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. Rt. #1, Ridgeley, West Virginia City or Town Mineral County State 	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED February 9, 1968	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS 		25a. REC'D BY REGISTRAR FEB 13 1968 25b. REGISTRAR'S SIGNATURE 	
23d. LOCATION (City or Town) Cumberland (County) Allegany (State) Md.					

01085

02222

18 days

15 days

12 days

10 days

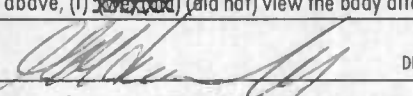

8 days

6 days

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
01896										
1. DECEASED-NAME (Type or print) VIRGINIA			First LAURA Middle AMBROSE Last			2a. DATE OF DEATH Month FEBRUARY Day 18 Year 1968		2b. HOUR 3:40 MIN.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 6-28-1908		6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HWFE.		12b. KIND OF BUSINESS OR INDUSTRY Own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY		13c. CITY OR TOWN RAWLINGS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Along 11. S. Rt. # 220	
14. FATHER'S NAME First JOHN Middle T. Last EMMART			15. MOTHER'S MAIDEN NAME First ANNIE Middle NORRIS Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 215-20-5412		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction--Coronary Occlusion hours 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease Years DUE TO, OR AS A CONSEQUENCE OF (c) With Marked Coronary Artery Disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Diabetes Mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1957 , 19 Feb. , 19 68 , that (I) (we) last saw the deceased alive on Feb. 18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE 					DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-20-68			
22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT					22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/21/68		23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.				
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland					25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE 			

01828

VIRGINIA

AVAROSE

FEBRUARY 18 1908

FEMALE

WHITE

6-21-1908

ALLEGANY

U. S. A.

CUMBERLAND

MEMORIAL HOSPITAL

WHITE

MD.

ALLEGANY HAWKINGS

JOHN

EMERY

ANNIE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

CUMBERLAND, MD.

U. S. A.

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30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
01897					CERTIFICATE OF DEATH					01887				
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR		
William			David		Anderson		Feb. 1 1968			5:30 P				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
Male		White		June 5, 1888			79 YRS.							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.		
Maryland			USA					Allegany						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Midland, Md.						Retired Miner			Coal					
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Md.			Allegany			Midland				none				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last		
James			Anderson						Elizabeth Hobough					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
Yes			War I			235-38-9467			Mrs. Catherine Green, Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 411.9 IMMEDIATE CAUSE (a) Myocardial Ischemia DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 19 60 to 26.1. 1968, that (I) (we) last saw the deceased alive on Jan 31 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE								22c. DATE SIGNED						
Dr. Leslie R. Miles, M.D.								Feb. 2, 1968						
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS						
State St., Lonaconing, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial			Feb. 5, 1968		Beverly Hill Cemetery		Morgantown, W. Va.							
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
James F. Scarpelli, Cumberland, Md.								FEB 8 1968						

01887

UNITED STATES OF AMERICA

01887

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RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

FOR STATE
HEALTH DEPT.

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01898

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01888

1. DECEASED-NAME (Type or Print) First Middle Last EMMA BLANCHE BEEGLE			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> Feb. 19 1968			2b. HOUR 1:30 P M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH SEPT 10 1884	6. AGE (In years month day) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year February 19 1968	
7a. BIRTHPLACE (State or foreign country) FLINTSTONE MD.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LECHLITER NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1209 BEDFORD STREET	
14. FATHER'S NAME First Middle Last SUMMERFIELD HINKLE			15. MOTHER'S MAIDEN NAME First Middle Last RHODA WOLFORD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) NONE		17. INFORMANT ADDRESS MR. JOHN BEEGLE 1209 BEDFORD ST CUMBERLAND MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fracture of ribs.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM 5:00 P Sept. 22 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell at home			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State 1209 Bedford St. Cumberland, Alleg. Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED February 19, 1968 ADDRESS (Street, city, town, or county) CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 21 FEB 68		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST CUMBERLAND MD.				25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) FOSTER			First E Middle BINGMAN Last			2a. DATE OF DEATH Month FEBRUARY Day 14 Year 1968		2b. HOUR 7:57 P.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1-30-1921		6. AGE (In years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Kelly Springfield		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PA.			13b. COUNTY BEDFORD		13c. CITY OR TOWN HYNDMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First JESSE Middle BINGMAN Last			15. MOTHER'S MAIDEN NAME First MALISSA Middle GILLUM Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 190-16-205		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 397.9										
DUE TO, OR AS A CONSEQUENCE OF (b) Auricular Fibrillation and Chronic Failure										
DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic Valvular Disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 414X Coronary Artery Disease, myocardial insufficiency										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4.11.60 , 19 2.14.68 , 19 , that (I) (we) last saw the deceased alive on 2.14.68 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE DR. WILLIAM P. JAMES MD					22c. DATE SIGNED 2.16.68		22d. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES			
22e. ADDRESS CUMBERLAND, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Madley Cemetery		23d. LOCATION (City or Town) (County) (State) Buffalo Mills, Pa. RD#1				
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman Pa.					25a. REC'D BY REGISTRAR FEB 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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01882

FEBRUARY 14 1968 1:57
BIRCHMAN
FOSTER
WHITE
1-30-1931
U. S. A.
ALLEGANY
MEMORIAL HOSPITAL
BEDFORD
JESSE
BIRCHMAN
MALISSA
CLIFTON

MEMORIAL HOSPITAL, CHAMBERLAND, MD.

DR. WILLIAM P. JAMES

DR. WILLIAM P. JAMES

CHAMBERLAND, MD.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
01900					01890						
1. DECEASED-NAME (Type or print) First Middle Last JOHN A. BOLT					2a. DATE OF DEATH Month Day Year FEB. 21st, 1968			2b. HOUR M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 5th, 1917			6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FOOD COUNCILOR-DIET			12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN ECKHART		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last WILLIAM J. BOLT					15. MOTHER'S MAIDEN NAME First Middle Last WILHELMINA GROETER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES		16b. SOCIAL SECURITY NO. W.W. 2 217-10-1209		17. INFORMANT Address MRS. OLIVE R. BOLT, ECKHART, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage 431.9 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-18-68	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331.8											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2-18 , 19 68 , to 2-21 , 19 68 , that (I) (we) last saw the deceased alive on 2-21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H.C. Diehl, M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-23-68		
22d. PHYSICIAN'S NAME (Type) H. C. DIEHL, M.D.					22e. ADDRESS 39 W, MAIN ST., FROSTBURG, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-24-68		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY			23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.				
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,					ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01981		01891	
1. DECEASED-NAME (Type or print) First Middle Last Daisy Mae Brant		2a. DATE OF DEATH Month 7 Day 1968 Year 2b. HOUR 11:45 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH Aug. 3, 1897	6. AGE (In years last birthday) 70 YRS. IF UNDER 1 YEAR MONTHS DAYS IE UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany Md.
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Retreat	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 208 Grand Avenue
14. FATHER'S NAME First Middle Last James Boxell	15. MOTHER'S MAIDEN NAME First Middle Last Alice Hamilton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address Daughter Mrs. Raymond Swach, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) Carcinoma Stomach DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1518			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May, 1967, to 2/7, 1968, that (I) (we) last saw the deceased alive on 2/7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE George M. Simons, M.D.		DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) George M. Simons, M.D.		22e. ADDRESS Memorial Hospital Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 10, 1968	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE Feb 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

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1965

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR	
Tammy Lee Breighner						Month Day Year			1:00	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
Female	White	Nov. 15, 1967	YRS. MONTHS DAYS	3	13	HOURS MIN.		Month Day Year	19 68	8:15
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.A.				Allegany			None	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			D.O.A. Memorial Hospital			None			None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Allegany		Oldtown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route # 1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17. INFORMANT ADDRESS				
First Middle Last			First Middle Last							
Unknown			Linda Therese Breighner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			Linda T. Breighner, Route #1, Oldtown, Maryland				
No			None							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										HOURS
IMMEDIATE CAUSE (a) 747.3 ACUTE PULMONARY EDEMA										
DUE TO, OR AS A CONSEQUENCE OF										
(b) PATENT FORAMEN OVANE										
PULMONARY ARTERY STENOSIS										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
(Deceased had been well and medically asymptomatic)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED	
EXAMINER'S NAME (Type)			Benedict Skitarelic, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			February 28, 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		March 2, 1968		Oldtown Methodist Cemetery			Oldtown, Allegany, Maryland			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John J. Hafer, Jr., 280 Baltimore, Md.						MAR 4 1968				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Charles H. Brown						Month Day Year Feb. 1st, 1968		2 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		June 7th, 1885		83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Allegany			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Frostburg		Miners Hospital		Ret. Miner		Coal			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegany		Frostburg				348 Welsh Hill	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Joseph H. Brown			Eliza Lee						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
			213-09-7334		Mrs. Emma M. Brown		348 Welsh Hill, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)								19 Hours	
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
443X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from 1-31, 1966, to 2-1, 1968, that (I) (we) last saw the deceased alive on 2-1, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
H. C. Diehl, M.D.		2/2/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
H. C. Diehl,		M.D.		39 W. Main Street, Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-4-68		Laurel Hill Cemetery		Barton, Allegany, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph R. Durst, Sr.,		Frostburg, Md.		FEB 6 1968		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01903

01894

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
RAYMOND		H.		BURKE	FEBRUARY 2, 1968		12:50 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE	WHITE		FEBRUARY 23, 1909		58 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
CUMBERLAND, MD.		U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND, MD.		MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				135 MULLEN ST., CITY	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First Middle Last		First Middle Last						Address	
HUGH		BURKE		HELEN		HANDLE		MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i> 410.9 DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Post-lateral basilar</i> DUE TO, OR AS A CONSEQUENCE OF <i>4 days</i> (c) <i>420.1</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/29/68, 19, to 2/2/68, 19, that (I) (we) last saw the deceased alive on 2/2/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
DR. R.J. WILLIAMS		122 SO. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/5/68		Davis Memorial Cemetery		Cumberland Allegany, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Philip B. Wendt 121 Memorial Ave. Cumb., Md.		DATE FEB 7 1968							

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FEBRUARY 2, 1948 12:30

CHURCH

RAYMOND

WHITE

MALE

ALLIANCE

CHURCHMAN, U.S.A.

CHURCHMAN, U.S.A.

122 S. 1ST ST., CHICAGO

CHURCHMAN

ALLIANCE

CHURCHMAN

HANDS

CHURCH

CHURCH

CHURCH

CHURCHMAN, U.S.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>01905</div> <div> <div>MD</div> <div>01895</div> </div>												
<div> <div>1. DECEASED-NAME (Type or print)</div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div>HERBERT R CHANDLER</div>										<div>2a. DATE OF DEATH</div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>2 10 68</div>		<div>2b. HOUR</div> <div>2:50</div> <div>P</div>
<div>3. SEX</div> <div>MALE</div>		<div>4. RACE</div> <div>WHITE</div>		<div>5. DATE OF BIRTH</div> <div>8-9-93</div>		<div>6. AGE (In years last birthday)</div> <div>74</div> <div>YRS.</div>		<div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div>		<div>IF UNDER 24 HRS.</div> <div>HOURS</div> <div>MIN.</div>		
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>PENNSYLVANIA</div>		<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>		<div>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>9. COUNTY OF DEATH</div> <div>ALLEGANY</div>						
<div>10. CITY OR TOWN OF DEATH</div> <div>CUMBERLAND</div>			<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>MEMORIAL HOSPITAL</div>			<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div>			<div>12b. KIND OF BUSINESS OR INDUSTRY</div>			
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>MD.</div>			<div>13b. COUNTY</div> <div>ALLEGANY</div>		<div>13c. CITY OR TOWN</div> <div>CUMBERLAND</div>		<div>13d. INSIDE CITY LIMITS?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>		<div>13e. STREET AND NUMBER</div> <div>617 GREENE ST.</div>			
<div>14. FATHER'S NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>GEORGE CHANDLER</div>			<div>15. MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>ELLA SMITH</div>									
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</div> <div>Yes, no, or unknown</div>			<div>16b. SOCIAL SECURITY NO.</div>			<div>17. INFORMANT</div> <div>MEMORIAL HOSPITAL</div>			<div>Address</div> <div>CUMBERLAND, MD.</div>			
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u></div> <div>4129</div> <div>DOE TO, OR AS A CONSEQUENCE OF</div> <div>(b) <u>Arteriosclerotic Cardio-Vascular Disease</u></div> <div>DOE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div> <div>Approximate Interval Between Onset and Death</div> <div>12 hrs</div> <div>5 yrs</div>												
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div> <div>4221</div> <div>Permeious Anemia</div>												
<div>19a. DATE OF OPERATION</div>		<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>			<div>20a. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		<div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>					
<div>21a. ACCIDENT WAS UNDERLYING</div> <div><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</div> <div>(If either, notify medical examiner)</div>		<div>21b. TIME OF INJURY</div> <div>HOUR A.M. Month Day Year</div> <div>P.M. 19</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>								
<div>21d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not while <input type="checkbox"/></div> <div>at work <input type="checkbox"/> at work <input type="checkbox"/></div>		<div>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</div>			<div>21f. LOCATION Street or R.F.D. No. City or Town County State</div>							
<div>22a. I certify that (I) (this hospital) attended the deceased from <u>12 Jan, 19 68</u>, to <u>10 Feb, 19 68</u>, that (I) (we) lost</div> <div>saw the deceased alive on <u>10 Feb, 19 68</u>, and that in (my) (our) opinion death occurred on the date and hour and from the</div> <div>causes stated above, (I) (we) (did) (did not) view the body after death.</div>												
<div>22b. SIGNATURE</div> <div>James B. Stegmaier</div> <div>DEGREE</div> <div>ATTENDING PHYS.</div> <div><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div>						<div>22c. DATE SIGNED</div> <div>12 Feb 68</div>						
<div>22d. PHYSICIAN'S NAME (Type)</div> <div>DR. JAMES STEGMAIER</div>						<div>22e. ADDRESS</div> <div>CUMBERLAND, MD.</div>						
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div>		<div>23b. DATE</div> <div>Feb. 14, 1968</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Sunset Memorial Park</div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Cumberland, Allegany, Md.</div>						
<div>24. FUNERAL DIRECTOR</div> <div>James F. Scarpelli, Cumberland, Md.</div>						<div>25a. REC'D BY REGISTRAR</div> <div>DATE FEB 15 1968</div>		<div>25b. REGISTRAR'S SIGNATURE</div>				

01202

HERBERT

CHANDLER

2 10

01202

AGE

WHITE

8-2-93

ALLEGANY

PENNSYLVANIA

U.S.A.

CHANDLER

GENERAL HOSPITAL

VT.

ALLEGANY

CHANDLER

2 10 GREENE

GEORGE

CHANDLER

ELIA

GENERAL HOSPITAL

CHANDLER, VT.

DR. JAMES STEWART

CHANDLER, VT.

FEB 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

01906										01896									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First		Middle		Last			2a. DATE OF DEATH Month 12 Day 12 Year 1968				2b. HOUR 6:20 ^A M					
3. SEX Female			4. RACE White			5. DATE OF BIRTH Dec. 13, 1905			6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN						
7a. BIRTHPLACE (State or foreign country) Italy			7b. CITIZEN OF WHAT COUNTRY? USA			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.										
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1011 Lafayette			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1011 Lafayette Ave.									
14. FATHER'S NAME First Middle Last Donald Ballarion			15. MOTHER'S MAIDEN NAME First Middle Last Philomenia Blasioli																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Mr. Lacy B. Cifala, Cumberland, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno-Ca of colon</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538																			
19a. DATE OF OPERATION 10-5-64			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <u>6-22, 1956</u> , to <u>2-12-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Ralph W. Ballin M.D.</u>												DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-14-68					
22d. PHYSICIAN'S NAME (Type) Dr. Dr. Ralph W. Ballin, MD			22e. ADDRESS 62 Greene St., Cumberland, Md.																
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 15, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.											
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE FEB 19 1968			25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>										

01504

01504

01504 of 01504

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01504 X

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR				
Harry			F.		Cole				Month Day Year 2-17-68 19 11		:30 P				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		Feb. 18, 1897		70 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year February 17, 68 19 11		:30 M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY			
Maryland			USA						Allegany			Railroad			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
Cumberland			SACRED HEART HOSPITAL-DOA			Retired Machinist									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Md.			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			115 N. Cedar St.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last Harry Cole			First Middle Last Olive Freeland												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
yes			(If yes give war or dates of service) War 1			705-05-4341			Mrs. Marie Cole, Cumberland, Md. - Wife						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF CORONARY OCCLUSION (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN --					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
4201															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?						
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
22a. ACTUAL SIGNATURE			Benedict Skitarelic			M.D.			22b. DATE SIGNED						
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			February 17, 1968						
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
						ADDRESS (Street, city, town, or county)			CUMBERLAND, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			Feb. 21, 1968			St. Mary's Cemetery			Cumberland, Md. Allegany						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
James F. Scarpelli, Cumberland, Md.						DATE FEB 23 1968			Charles Judge						

01831

01831

01831

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

01908

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01898

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
LILLIAN JOSEPHINE COLLINS					FEB			3	1968	6 A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
FEMALE	WHITE	JULY 19, 1900		67 YRS	MONTHS DAYS		HOURS MIN		FEB Day 3 Year 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNA.		USA				ALLEGANY Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		SACRED HEART HOSP.			HOUSEWIFE			HOUSEWIFE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND		ALLEGANY		CUMBERLAND		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD #1 BOX 534		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
LEWIS GREEN					JOSEPHINE LINDERMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO		213-16-9346A		CHESTER R. COLLINS RFD #1 BOX 534 CUMBERLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 MYOCARDIAL INFARCTION, LEFT DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS, LEFT DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 48 HOURS ----
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NDT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Benedict Skitarelic				M.D.		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		February 3, 1968		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
BURIAL		6 FEB 68		MT. HERMAN CEMETERY		RFD #2 CUMBERLAND		ALLEGANY MD.		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. LEE SILCOX 404 DECATUR ST. CUMBERLAND, MD.						FEB 6 1968		John Lee Judge		

01884

01884

[Faint signature]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01909

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01899

1. DECEASED-NAME (Type or Print)		First IDA	Middle MAE	Last CONWAY		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> ESTI- FEB. 20, 1968				2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH AUG. 20, 1891		6. AGE (in years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 19	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				2d. HOUR M
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WORK			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 122 CENTER STREET		
14. FATHER'S NAME First Middle Last JOHN G. MASON		15. MOTHER'S MAIDEN NAME First Middle Last REBECCA HOBEL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 182-01-6145B		17. INFORMANT ADDRESS 89 BROADWAY, MRS. MARY EVANS, FROSTBURG, MD. 21532						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (b) FRACTURED RIBS, MULTIPLE INJURIES DUE TO, OR AS A CONSEQUENCE OF (c) (FELL DOWN STEPS AT HOME) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 7 DAYS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9000										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 7:00 P.M. 2-12 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell down 15 steps at home						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HOME		21f. LOCATION Street or R.F.D. No. City or Town County State 122 CENTER ST. FROSTBURG, ALLEGANY, MARYLAND						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED FEBRUARY 19, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 22 1968		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.				
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532				ADDRESS		25a. REC'D BY REGISTRAR FEB 26 1968		25b. REGISTRAR'S SIGNATURE Charles Jones		

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>01910</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01900</div>											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Vera Marie Cook						<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> Feb. 7, 1968			<input checked="" type="checkbox"/> 4:35 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
Female	White	June 26, 1923	44 YRS.	MONTHS	DAYS	HOURS	MIN.	February 7, 1968			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Rd. 3 Rawlings			R.D. 3 Rawlings			house wife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Allegany			Rawlings			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
First Middle Last			First Middle Last			R.D. Rawlings					
Wesley D. Fike			Naomi Harvey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
no						Jesse W. Cook Rawlings, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										20 Hours	
IMMEDIATE CAUSE (a)										Cardiac Tamponade	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Rupture of Dissecting Aneurysm of Aorta	
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
451X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
CAUSE OF DEATH				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 7, 1968					
						ADDRESS (Street, city, town, or county) Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2/10/68		Queens Point			Keyser Mineral W. Va.			
24. FUNERAL DIRECTOR <i>E. J. Boral</i>						ADDRESS Westernport, Md.			25a. REC'D BY REGISTRAR DATE FEB 13 1968		
									25b. REGISTRAR'S SIGNATURE <i>J. J. Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR A	
GEORGE		P.		CRUMP				(2) FEBRUARY 22, 1968		1:30 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 3, 1887		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RET. MINER		12b. KIND OF BUSINESS OR INDUSTRY COAL MINES					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER BOX 36, MT. SAVAGE, MD.			
14. FATHER'S NAME First Middle Last GEORGE CRUMP		15. MOTHER'S MAIDEN NAME First Middle Last BRODE, MARGARET									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-09-8575		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1621</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerosis-generalized--Chronic Bronchitis--Silicosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u> </u> , to <u>Feb. 22, 1968</u> , that (I) <u>(xx)</u> last saw the deceased alive on <u>Feb. 21, 1968</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(xx)</u> (did) <u>(xx)</u> view the body after death.											
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED 2-23-68		22d. PHYSICIAN'S NAME (Type) DR. O. HIMMELWRIGHT		22e. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-24-68		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE'S CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, ALLEGANY, MD.					
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,		ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
John Donaldson								Month Day Year	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2c. DATE PRONOUNCED DEAD	
Male		White		11/17/		61 YRS.		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR	
MD.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany		PM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		4-30M	
Lonaconing		Jackson St.		Retired Miner					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		Allegany		Lonaconing				Jackson St.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
James Donaldson								Oda Shockey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		182-01-3556		Donaldson		Ida Richardson, Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Coronary Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109				DUE TO, OR AS A CONSEQUENCE OF		Coronary Sclerosis		Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)				---	
				(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)		4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
		HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2/6/1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)		Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		2/9/1968		Oak Hill Cemetery		Lonaconing, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George Eichhorn		Lonaconing, Md.		FEB 13 1968					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01913										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01903									
Item 16b Film G398 3/7/68 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR M														
RICHARD					CLAY					EDWARDS					FEBRUARY					29, 1968									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					7. IF UNDER 1 YEAR MONTHS DAYS					8. IF UNDER 24 HRS HOURS MIN.				
MALE					NEGRO					DECEMBER 7, 1888					79														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md.									
CUMBERLAND, MD.					U.S.A.										ALLEGANY														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
FROSTBURG					MINERS HOSPITAL					MINER										COAL									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					ALLEGANY					FROSTBURG										150 W. MECHANIC STREET									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
RICHARD					EDWARDS					ANNIE					BUTLER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
					214-01-3641					MR. MERVIN EDWARDS,					PARK ST. FROSTBURG,					MARYLAND									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 515.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Silicosis & asthma</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5230										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>2/29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>John B. Davis,</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>3/3/68</u>														
22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.										22e. ADDRESS 2 BROADWAY, FROSTBURG, MD., 21532																			
23a. BURIAL, CREMATION, or other disposal (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
BURIAL					MARCH 3, 1968					FROSTBURG MEM. PARK					FROSTBURG, ALLEGANY, MD.														
24. FUNERAL DIRECTOR <u>MARILLOU M. SOWERS</u>										25a. REC'D BY REGISTRAR <u>5 1968</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>														

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. TIME	
Arthur James Eisentrout						Feb. 4, 1968		4:35 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD		2d. TIME	
Male	White	Feb. 27, 1885	82 YRS.			February 4, 1968		4:35 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U S A				Allegany		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			Memorial Hospital			Retired Janitor		Celanese Corp.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Allegany		La Vale		1 Ruth Street		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Leopold Eisentrout			Maria Bowley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			214-01-3645A		Mrs. Emma B. Eisentrout, 1 Ruth St. La Vale, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF Coronary sclerosis (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		February 4, 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Feb. 7, 1968		Frostburg Memorial Park		Frostburg, M Allegany Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John J. Hafer, Jr.			230 Balto Ave. Cumberland Md.			FEB 8 1968		Charles J. Hafer	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
01915		01905							
1. DECEASED-NAME (Type or Print)		First MARY		Middle G.		Last FANNON		2a. DATE KNOWN <input type="checkbox"/> Month Day Year OF DEATH ESTI- <input type="checkbox"/> FEB. 16 19 68	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH SEPT. 6, 1880		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		2c. DATE PRONOUNCED DEAD Month FEB. Day 16 Year 1968	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D. O. A. SACRED HEART				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WORK		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First JOHN		Middle CARNEY		Last BRIDGET MULLANEY		15. MOTHER'S MAIDEN NAME First BRIDGET MULLANEY		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-54-7843		17. INFORMANT ADDRESS RAYMOND FANNON, MT. SAVAGE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) --								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic		M.D. Benedict Skitarelic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED FEB. 16, 1968	
EXAMINER'S NAME (Type)		ADDRESS Cumberland, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 19 '68		23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532				ADDRESS		25a. REC'D BY REGISTRAR FEB 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

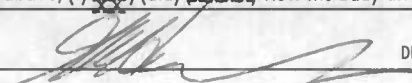

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01906									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Henry			H. Fazenbaker			February 1, 1968		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		5/1/1872		95 YRS.		MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER 24 HRS. HOURS MIN	
Maryland		U.S.A.				Allegany		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Lonaconing		Knapp Meadow		Retired Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md		Allegany		Lonaconing				Knapp Meadow	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Marcus Fazenbaker			Ellen Broadwater						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no					Marshall Fazenbaker		Lonaconing, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Myocardial Ischemia								?	
DUE TO, OR AS A CONSEQUENCE OF									
(b) Coronary Insufficiency								5 years	
DUE TO, OR AS A CONSEQUENCE OF									
(c) Generalized Atherosclerosis								years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 26, 1968, to Feb. 1, 1968, that (I) (we) last saw the deceased alive on Jan. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
L.R. MILES, JR. MD								22c. DATE SIGNED	
								2-1-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
L.R. MILES, JR. MD				LONA CONING MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/3/1968		Memorial Park		Frostburg A. Md			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George Eichhorn				Lonaconing, Md.		DATE FEB 5 1968		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>01917</div> <div> <div>01907</div> <div>01907</div> </div>																
1. DECEASED-NAME (Type or print)			First ALFRED			Middle LEE			Last GEORGE			2a. DATE OF DEATH FEBRUARY 17 1968			2b. HOUR 8:20 PM	
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 4-18-1901			6. AGE (In years last birthday) 66 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired working Stores Dept.			12b. KIND OF BUSINESS OR INDUSTRY Railroad							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER 142 HUMBERD ST.				
14. FATHER'S NAME First ALBERT			Middle GEORGE			Last GEORGE			15. MOTHER'S MAIDEN NAME First BERTHA			Middle RICE			Last RICE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 705-05-4435			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchitis--Emphysema--Asthma DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1621 Arteriosclerotic Cardiovascular Disease																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19__, to Feb. 17, 1968 , that (I) (we) last saw the deceased alive on Feb. 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE 			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2-20-68							
22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT			22e. ADDRESS CUMBERLAND, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 21, 1968			23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegan, Md.							
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE FEB 23 1968			25b. REGISTRAR'S SIGNATURE 							

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ALBERT GEORGE FEBRUARY 17 1908:206

WHITE 1-18-1901 66

U. S. A. ALLEGANY

CHURCHLAND HOSPITAL

ALLEGANY CHURCHLAND X 142 THIRD ST.

ALBERT GEORGE BIRTH

CHURCHLAND HOSPITAL, CHURCHLAND, NO.

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VR A15 (4)
FORM REV. 1/68

01918												01908																																																											
1. DECEASED-NAME (Type or print)												20. DATE OF DEATH												2b. HOUR																																															
BABBARA												FEBRUARY												4:05																																															
3. SEX												4. RACE												5. DATE OF BIRTH												6. AGE (In years last birthday)												IF UNDER 1 YEAR		IF UNDER 24 HRS.																					
FEMALE												WHITE												OCTOBER 9, 1888												81												MONTHS		DAYS		HOURS		MIN																	
7a. BIRTHPLACE (State or foreign country)												7b. CITIZEN OF WHAT COUNTRY?												8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												9. COUNTY OF DEATH												Md.																							
MARYLAND												U.S.A.																								ALLEGANY																																			
10. CITY OR TOWN OF DEATH												11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)												12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)												12b. KIND OF BUSINESS OR INDUSTRY																																			
CUMBERLAND												MEMORIAL HOSPITAL																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)												13b. CITY OR TOWN												13d. INSIDE CITY LIMITS?												13e. STREET AND NUMBER																																			
STATE												CUMBERLAND												YES <input type="checkbox"/> NO <input type="checkbox"/>												801 BEDFORD ST., CITY																																			
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME												16. WAS DECEASED EVER IN U.S. ARMED FORCES?												16b. SOCIAL SECURITY NO.												17. INFORMANT												Address											
First Middle												First Middle												Yes, no, or unknown												-												MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND																							
Henry												Susan												No																																															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
PART 1. DEATH WAS CAUSED BY:																																																																							
IMMEDIATE CAUSE (a)												6 days																																																											
431.9																																																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												(b) 6 days																																																											
												(c) 5 yrs																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																							
331.8																																																																							
21a. ACCIDENT WAS UNDERLYING												21b. TIME OF INJURY												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																																															
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												HOUR A.M. Month Day Year																																																											
21d. INJURY OCCURRED												21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)												21f. LOCATION																																															
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																								Street or R.F.D. No.												City or Town												County												State											
22a. I certify that (I) (this hospital) attended the deceased from												22b. SIGNATURE												22c. DATE SIGNED																																															
saw the deceased alive on												CLAY E. DURRETT												2/3/68																																															
causes stated above, (I) (we) (did) (did not) view the body after death.																																																																							
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																																																											
DR. CLAY E. DURRETT												236 VIRGINIA AVENUE, CUMBERLAND, MD.																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City or Town) (County) (State)																																			
Burial												2/6/68												Hillcrest Burial Pk.												Cumberland Maryland																																			
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE																																															
Louis Stein Inc. Cumb. MD.												DATE												FEB 6 1968																																															

01314

01304

SABARA

HANES

FEVERARY 2, 1902

WHITE

FEWALE

OCTOBER 2, 1902

A. C. CANT

WYLAND

CHERRYLAND

CHERRYLAND

WYLAND

ALLEGY

DO. REDDING ST. CITY

WYLAND

WYLAND

MEMORIAL HOSPITAL, CHERRYLAND, WYLAND

DO. CAY E. SURETT

300 VIRGINIA AVENUE, CHERRYLAND, WYLAND

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First		Middle		Last		
Jacob			Bernard		Hamilton				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2a. DATE KNOWN OF ESTI-DEATH MATED	2b. HOUR
Male	White	July 11, 1899	68 YRS.					Feb. 9, 1968	4:45 A.M.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany		Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland	D.O.A. Sacred Heart		Retired Pipefitter		Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
W.Va.	Mineral	Wiley Ford	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	None					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Jacob L. Hamilton				Editha Larman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS					
no		Mrs. Lola Hamilton, Wiley Ford, W.Va. Wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109 IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>								Sudden	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Coronary Sclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH		HOUR A.M. P.M. 19							
21d. INJURY OCCURRED	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Feb. 9, 1968			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial	Feb. 12, 1968	Fort Ashby Cemetery		Fort Ashby, W. Va.		Mineral			
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				FEB 13 1968					

01310

01310



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 01920 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01910 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>																
1. DECEASED-NAME (Type or print)			First JAMES			Middle WILLIAM			Last HARDINGER			2a. DATE OF DEATH Month 02 Day 13 Year 68			2b. HOUR 8:45 PM	
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 09-11-99			6. AGE (In years lost birthday) 68 YRS.			IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		
7a. BIRTHPLACE (State or foreign country) PENNA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY Md.							
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RUBBER WORKER			12b. KIND OF BUSINESS OR INDUSTRY TIRE CO.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 10 MARIAN ST.				
14. FATHER'S NAME First WILLIAM Middle Last HARDINGER			15. MOTHER'S MAIDEN NAME First OCEOLA Middle Last TWIGG													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-07-0628			17. INFORMANT Address HOSPITAL RECORD, 900 SETON DRIVE., CUMB.MD.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a)																
DUE TO, OR AS A CONSEQUENCE OF																
ARTERIOSCLEROTIC HEART DISEASE												30 YRS.				
(b)																
DUE TO, OR AS A CONSEQUENCE OF																
LOBAR PNEUMONIA												4 DAYS				
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
EMPHYSEMA ACUTE, CHRONIC BRONCHIAL ASTHMA, ARTERIOSCLEROSIS, GENERALIZED																
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NONE										
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY NONE (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from FEB. 11, 1968 , to FEB. 13, 1968 , that (I) (we) lost 8:45 P.M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>James P. Hallinan</i>												22c. DATE SIGNED 2-14-68				
22d. PHYSICIAN'S NAME (Type) JAMES P. HALLINAN												22e. ADDRESS 140 BEDFORD STREET, CUMB., MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/16/1968			23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md							
24. FUNERAL DIRECTOR <i>John J. Hafer, Jr.</i>												25a. REC'D BY REGISTRAR Feb 19 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		

01280

01280

JAMES WILLIAM HARRINGER 02 18 1954

MALE WHITE 00-11-00 ALLEGANY COUNTY

CHANDLER LAND SACRED LEAST HOSPITAL RUBEN WORKER TITLE CO. ALLEGANY CHANDLER LAND X 10 HALLAM ST.

WILLIAM HALLAM HALL OF GER COGOLA TWIGG

NO 214-07-002 HOSPITAL RECORD, 900 SETON DRIVE, COLUMBIA

WOOD ROLL F LURE, WHITE

INTERPOLATED HEAT 0-25-25

LOAN R PRINCE

BLACK SEAL CUTS, CHOW C BROWN L STALL, INTERPOLATED 2, 25-25-25

HOME

HOME

HOME

FEET, LL, 2 FEET, LL, 2

FEET, LL, 2

JAMES F. HALLAM 140 BEDFORD STREET, CLARK, MD. 21502

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form - PM-3. Page 5 may be retained for your files.

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01921

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01911

1. DECEASED-NAME (Type or Print) <i>Mary</i>		First <i>Mary</i>		Middle <i>Marie</i>		Last <i>Harris</i>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Feb.</i> Day <i>17,</i> Year <i>1968</i>		2b. HOUR <i>3:30</i> PM	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Jan. 12, 1912</i>	6. AGE (in years last birthday) <i>56</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>Feb.</i> Day <i>17,</i> Year <i>1968</i>		2d. HOUR <i>3:59</i> PM			
7a. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Allegany</i>				Md.	
10. CITY OR TOWN OF DEATH <i>Cumberland,</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>228 Paca St.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Allegany</i>		13c. CITY OR TOWN <i>Cumberland,</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>228 Paca St.</i>			
14. FATHER'S NAME <i>Andrew</i>		First <i>Andrew</i>		Middle <i>C.</i>		Last <i>Paugh</i>		15. MOTHER'S MAIDEN NAME <i>Manda</i>		First <i>Manda</i> Middle <i>L.</i> Last <i>Hefner</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>234-44-2134</i>		17. INFORMANT <i>Mr. Jack Harris,</i>		ADDRESS <i>228 Paca St. Cumberland, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EMBOLISM</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>924x</i> (b) <i>BURNS OF INNER THIGHS</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>SUDDEN</i> <i>DAYS</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>7170</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>2 P.M. ? ? ? 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Spilled hot liquid on lap.</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>228 Paca St.</i>		City or Town <i>Cumberland,</i>		County <i>Allegany</i>		State <i>Md.</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) <i>Benedict Skitarelic, M. D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Feb. 17, 1968</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/20/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maplewood Cemetery</i>		23d. LOCATION (City or Town) <i>Elkins,</i>		(County) <i>Randolph W. Va.</i>		(State)	
24. FUNERAL DIRECTOR <i>H. Wayne George</i>				ADDRESS <i>Cumberland, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

11010

11010

11010

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

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01922

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01912

1. DECEASED-NAME (Type or Print) ERNEST E. HARTMAN, SR.			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year FEB. 16 1968			2b. HOUR 8:00 AM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH AUG. 6, 1899	6. AGE (in years last birthday) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year FEBRUARY 16, 1968		2d. HOUR 1:00 PM
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md	
10. CITY OR TOWN OF DEATH RFD CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEXICO FARMS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY NOVELTY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER MEXICO FARMS		14. FATHER'S NAME First Middle Last ROBERT J. HARTMAN		15. MOTHER'S MAIDEN NAME First Middle Last SARAH DAWSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 214 05 9562		17. INFORMANT STANLEY O. HARTMAN, RFD CUMBERLAND, MD.		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) ---						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/16/68	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 19, 1968		23c. NAME OF CEMETERY OR CREMATORY DAVIS MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MARYLAND	
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR FEB 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

01210

05210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
NAOMI				GALE		HORNER	FEBRUARY	Month	Day	Year	10pm
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE		WHITE		MARCH 2, 1890			77		MONTHS	DAYS	HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
PENNSYLVANIA		USA				ALLEGANY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			SACRED HEART HOSP.			HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			ALLEGANY		FROSTBURG				ROUTE # 1		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
SIMON			SMITH		HANNAH DUNLAP						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
NO			172-18-8555		HOSPITAL RECORD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melanoma of the breast</i> 174X DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic Ca of breast</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastatic Ca of breast</i> 170X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 26, 1968, to Feb 28, 1968, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Blane M. Schindler</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-29-68			
22d. PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.						22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		March 2, 1968		Hyndman Cemetery		Hyndman, Bedford Co., Pa.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harvey H. Zeigler, Hyndman, Pennsylvania						MAR 6 1968		<i>Charles Judge</i>			

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HOSPITAL RECORD

13 GREEN ST., CHURCHLAND, MO. 21002

OLIVE H. SCHINDLER, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01914

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR	
MARGARET			B.		HOSKEN	FEB. Month 1, Day 1968 Year			M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE		WHITE		OCT. 23, 1878		89 YRS.		MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
MARYLAND		U.S.A.				ALLEGANY		OWN HOME		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				
FROSTBURG			MINERS HOSPITAL			HOUSE WORK				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		FROSTBURG				DEPOT TERRACE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Lost			First Middle Lost							
JOHN			HOSKEN			ELIZABETH DEMPSTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
			220-52-9833			MRS. WM. MCGREGOR, FROSTBURG, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Myocardial Ischemia										
413.9 DUE TO, OR AS A CONSEQUENCE OF										
(b) Coronary Insufficiency										years
DUE TO, OR AS A CONSEQUENCE OF										
(c) Atherosclerosis										years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from 1964, to Feb. 1, 1968, that (I) (we) last saw the deceased alive on Jan 31, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		22c. DATE SIGNED		
DR. LESLIE MILES						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		2.5.68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
						Frostburg Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
BURIAL		FEB. 3, 1968		F.B.G. MEMORIAL PARK		FROSTBURG, MD.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOSEPH R. DURST, SR., FROSTBURG, MD. 21532						DATE FEB 6 1968		Charles Judge		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH			2b. HOUR
JOHN WILLIAM HUTSON						Feb. 24, 1968			9:45 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	2d. HOUR
MALE	WHITE	NOV 22, 1880	87 YRS	MONTHS	DAYS	HOURS	MIN	February 24, 1968	9:45 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U. S. A.				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND			SYLVAN RETREAT			CUMBERLAND			STREET DEPT.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
MARYLAND			ALLEGANY		CUMBERLAND		BROOKS HOTEL		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
JOHN HUTSON			SARAH MELLOTT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO			159-16-0514		MRS EDWARD E. LITTLE 413 PULASKI ST MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X Lobar Pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF									10 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 490X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Benedict Skitarelic						February 24, 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
B ENEDICT SKITARELIC, M.D.						CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL		27 FEB 68	ROSEHILL CEMETERY			CUMBERLAND ALLEGANY MD.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. LEE SILCOX 404 DECATUR ST CUMBERLAND					FEB 27 1968		Charles Judge		

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FOR STATE
DEPARTMENT



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U.S. DEPARTMENT OF STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH												CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR											
AMELIA				May JACKSON				Feb Month 10 Day Year 68				1:35 A M											
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Female		white		Mar 20 - 1886				81-82 YRS.				11 MONTHS 19 DAYS		HOURS MIN.									
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH											
Maryland				U.S.								Allegany Md.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland				Allegany County Infirmary				House wife				Own home											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER							
Md				Allegany				Cumberland				YES				26 Pennsylvania Ave							
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last																			
George Kerns				Elizabeth Cruthers																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address											
No				R20-52-9835-T				P.O. Box 599, Allegany County, IN FIRMARY RECORDS				CUMBERLAND, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Arterio sclerosis												many years											
DUE TO, OR AS A CONSEQUENCE OF																							
(b) Chr. H.S. C.V. & with Hypertension												many years											
DUE TO, OR AS A CONSEQUENCE OF																							
(c) Senility												years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																							
443X EVA '67 Chr. Brain Syndrome																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from Dec 13, 1967, to Feb 10, 1968, that (I) (we) last saw the deceased alive on 12-18-1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE John A. Topper M.D.												22c. DATE SIGNED 2-10-68											
22d. PHYSICIAN'S NAME (Type) John A. Topper MD												22e. ADDRESS Memorial Hospital Cumberland Md											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
Burial				Feb. 15, 1968				Rose Hill Cemetery				Cumberland Allegany, Md.											
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.												25a. REC'D BY REGISTRAR DATE FEB 15 1968				25b. REGISTRAR'S SIGNATURE Charles Justice							

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1003. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
TOM REV. 1/68

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01917

1. DECEASED-NAME (Type or Print)		First		Middle		Last		20. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR
JAMES		E		KALBAUGH				FEB 27		19	68	12:03	AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE	WHITE	6-16-1897		70 YRS		MONTHS		DAYS		Month		Day	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.	
MARYLAND		USA				ALLEGANY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND		MEMORIAL HOSPITAL											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
MD.		ALLEGANY		MC COOLE				41 LLEWELLYN STREET					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
JOSEPH		KALBAUGH		LAURA		MCINTEE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS							
no		215-10-8038		MEMORIAL HOSPITAL, CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANASARCA, GENERALIZED</u> DUE TO, OR AS A CONSEQUENCE OF <u>PORTAL CIRRHOSIS</u> (b) <u>---</u> DUE TO, OR AS A CONSEQUENCE OF <u>---</u> (c) <u>---</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>571.8</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		22b. DATE SIGNED		22c. REGISTRAR'S SIGNATURE									
EXAMINER'S NAME (Type)		FEBRUARY 27, 1968		BALTO. PIKE, CUMB.									
DR. BENEDICT SKIAARELIC													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		2/29/68		Philos		Westernport Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE							
E. J. Goul		Westernport, Md.		FEB 29 1968		J. Charles Jagger							

MEDICAL CERTIFICATION

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Medical Examiner, Baltimore, Md.

ON STATE HEALTH BOARD

JAMES

KALBAUGH

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KAYLAND

USA

CH. RYLAND

MEMORIAL HOSPITAL

ALGERNY

GOULD

ALGERNY, N.Y. LEWIS, N.Y. GOULD

JOSEPH

KALBAUGH

MAUNA

MAUNA

MEMORIAL HOSPITAL, CH. RYLAND, MD.

ALGERNY, N.Y. LEWIS, N.Y. GOULD

ALGERNY, N.Y. LEWIS, N.Y. GOULD

DR. LEWIS SKINARETIC

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ALGERNY, N.Y. LEWIS, N.Y. GOULD

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01928										01918																													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month			Day			Year			2b. HOUR															
Harry			Franklin			Kifer						FEB.			7,			1968			5:30			M															
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD			Month			Day			Year			2d. HOUR									
Male			White			Aug. 5, 1915			52 YRS.			MONTHS			DAYS			HOURS			MIN.			FEBRUARY			7,			1968			5:30			M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH																														
Maryland			U S A			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany																					Md.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																														
Cumberland			Sacred Heart Hospital			Bobbins Stores			Celanese Corp.																														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																											
Penn.			Bedford			Artemas			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			-----																											
14. FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME			First			Middle			Last																		
Franklin									Kifer			Melinda									Crabtree																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																														
No			220-10-4576			Mrs. Eulah C. Kifer			Artemas, Pa.																														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTRAPERICARDIAL HEMORRHAGE RUPTURE OF DISSECTING ANEURYSM										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HOURS "																			
4410																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										451K																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED																			
ACTUAL SIGNATURE <i>Benedict Skitarellic</i> M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> FEBRUARY 7, 1968																			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.										ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)									
Burial										Feb. 11, 1968										Sunset Memorial Park										Near Cumberland Alleg Md									
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
John J. Hafer, Jr.										230 Balto Ave. Cumberland, Md										FEB 13 1968										<i>Charles Jones</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
01919											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
ROBERT		J.		KILGANNON,		FATHER		FEBRUARY 23, 1968		A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		2-7-93		75 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
IRELAND		U.S.A.				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		PREST		CHURCH					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
WEST VA. MARXKAND		RIDGELEY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		160 MAIN ST. RIDGELEY, WEST VA					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Thady		KILGANNON						KATHERINE		HARTE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT							
NO		233-72-2658		HOSPITAL RECORD- SACRED HEART HOSPITAL 900 SETON DRIVE, CUMB., MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Carcinoma prostate											
DUE TO, OR AS A CONSEQUENCE OF (b) with multiple metastases											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
177X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from June 18, 1968, to June 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS							
Howard L. Tolson		2-23-68		122 S. Center St., Cumberland, Md.							
22e. PHYSICIAN'S NAME (Type)		22f. ADDRESS		22g. DATE							
Howard L. Tolson		122 S. Center St., Cumberland, Md.		FEB 27 1968							
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. (County)		23f. (State)	
Burial		2/26/68		St. Marys Cem		Cumberland		Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Louis Stein Inc.		Cumb. Md.		DATE		FEB 27 1968					

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ROBERT	1.	KILGUBING, FATHER	FEBRUARY 23, 1900	A
MALE	WHITE	2-7-03	24	
IRELAND			ALLIANCE	
CORRIBLAND		SACRED HEART HOSPITAL	PREST	CHURCH
WEST W. HANNAH NARRABEE	11-1-11	11-1-11	180 MAIN ST. (CET. Y. 123)	
TERRY	KILGUBING	COHEN	HART	
232-73-262	HOSPITAL RECORD - DOG SET	COHEN	COHEN	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1000. 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01920

1. DECEASED-NAME (Type or Print) IDA J. KING		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year 2-18-68 19 68		2b. HOUR 7:20 A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH NOV. 2, 1874	6. AGE (In years last birthday) 93 YRS.	7c. DATE PRONOUNCED DEAD February 18 19 68
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY Md.
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN LA VALE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last JOHN O. O'HAVER		15. MOTHER'S MAIDEN NAME First Middle Last LYDIA ARONHALT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MARY E. ROBINETTE LA VALE, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 428X Acute Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4227 (b) Chronic Myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 11 -----
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Fracture surgical neck of left femur				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 5:00 P.M. 2-12-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell at home
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State 549 B. Street. LaVale. Maryland
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED FEB. 18, 1968
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER XX		
		ADDRESS CUMBERLAND, MD. CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE feb. 21, 1968	23c. NAME OF CEMETERY OR CREMATORY POPE CEMETERY	23d. LOCATION (City or Town) (County) (State) GORMAN, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR FEB 23 1968 25b. REGISTRAR'S SIGNATURE [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

M 01931										M 01921									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Edward First Middle Last Kirkwood					2a. DATE OF DEATH 2/10/1968 Month Day Year					2b. HOUR M									
3. SEX Male			4. RACE White			5. DATE OF BIRTH 12/22/1909			6. AGE (In years last birthday) 58 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.										
10. CITY OR TOWN OF DEATH Lonaconing			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Railroad St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) County Employee			12b. KIND OF BUSINESS OR INDUSTRY Truck Driver										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Allegany			13c. CITY OR TOWN Lonaconing			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Railroad ST.							
14. FATHER'S NAME First Middle Last John Kirkwood					15. MOTHER'S MAIDEN NAME First Middle Last Agnes Gorrie														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address La Vern Kirkwood, Lonaconing, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary Atherosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 6 mos. years									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1968 to Feb. 10, 1968 , that (I) (we) last saw the deceased alive on Feb. 6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.										22b. SIGNATURE L.R. Miles, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 2.12.68				
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.			22e. ADDRESS LONA CONING MD 21539																
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/12/1968			23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.										
24. FUNERAL DIRECTOR GEORGE EICHHORN					ADDRESS Lonaconing, Md.					25a. REC'D BY REGISTRAR FEB 13 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) SIMON			First Middle Last			2a. DATE OF DEATH Month February Day 28 Year 1968			2b. HOUR 5:56 AM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 2-3-1882			6. AGE (In years lost birthday) 86 YRS.		
7a. BIRTHPLACE (State or foreign country) GERMANY			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 111 N. CHASE STREET			14. FATHER'S NAME First LEON Middle KOCHMAN Last			15. MOTHER'S MAIDEN NAME First JOHANNA Middle LOEB Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4273 IMMEDIATE CAUSE (a) Myocardial Failure beginning Dec. 27, 1967 DUE TO, OR AS A CONSEQUENCE OF (b) Complete Left Bundle Branch Block DUE TO, OR AS A CONSEQUENCE OF (c) ?? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4330									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) / lower lung. Hypertrophic Prostatitis, Bladder retention, Diabetes Mellitus, Infarct Right											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 27, 1967 , to Feb. 27, 1968 , that (I) (we) last saw the deceased alive on Feb. 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Samuel Jacobson</i>									22c. DATE SIGNED Feb. 28, 1968		
22d. PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON									22e. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 2/29/68			23c. NAME OF CEMETERY OR CREMATORY East View Cem.			23d. LOCATION (City or Town) (County) (State) Cumberland Md.		
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE MAR 4 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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OFFICE OF DEATH

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NO. 14

FEBRUARY 28

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

01933										01923									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH									
First Middle Last HILDA K KOELKER										Month Day Year 02 23 68									
3. SEX FEMALE										2b. HOUR 6:20PM									
4. RACE WHITE										5. DATE OF BIRTH 09-12-94									
6. AGE (In years last birthday) 73										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? USA									
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY COUNTY									
10. CITY OR TOWN OF DEATH CUMBERLAND										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL									
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY HOME									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY ALLEGANY									
13c. CITY OR TOWN CUMBERLAND										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
13e. STREET AND NUMBER MECHANIC STREET																			
14. FATHER'S NAME First Middle Last ERNST JAHN										15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH STRAUB									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO										16b. SOCIAL SECURITY NO. 220-03-7266									
17. INFORMANT HOSPITAL RECORD, 900 SETON DR, CUMB., MD. 21502										Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ARTERIOSCLEROTIC HEART DISEASE (b) DIABETES MELLITUS (c) 2 DAYS 10 YRS. 10 YRS.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ENDERITIS OBLITERANS, GANGRENE, RIGHT FOOT 2 MO. MID-THIGH AMPUTATION 2 DAYS.																			
19a. DATE OF OPERATION 2-21-68										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE, RIGHT FOOT									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NONE																			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State JAN 15, 19 68 FEB. 23, 19 68																			
22. I certify that (I) (this hospital) attended the deceased from JAN 15, 19 68 to FEB. 23, 19 68 , that (I) (we) last saw the deceased alive on FEB. 23, 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. 6:20 PM																			
22b. SIGNATURE James P. Hallinan M.D.										22c. DATE SIGNED 2-25-68									
22d. PHYSICIAN'S NAME (Type) JAMES P. HALLINAN, M.D.										22e. ADDRESS 140 BEDFORD STREET, CUMB., MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 2/26/1968									
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park										23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md.									
24. FUNERAL DIRECTOR John J. Hafer, Jr.										25a. REC'D BY REGISTRAR FEB 27 1968									
25b. REGISTRAR'S SIGNATURE Charles Judge																			

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HOSPITAL RECORDS

HOSPITAL RECORD, DEPT. OF COM. IND. 51205

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DATE RECEIVED: 4 JUL 1964

140 BEDFORD STREET, CHICAGO, ILL. 60610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 copies of this certificate and 2 copies of the death certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 1/68

01934		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01924					
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Magdalene (Mrs)		Kolberg						2 19 68 Month Day Year		2:55 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9/13/1877		6. AGE (In years lost birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County, Cumberland Md.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 215 Maryland Ave.			
14. FATHER'S NAME Leslie Haning		First Middle Last		15. MOTHER'S MAIDEN NAME Minerva Brooks		First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 220-10-7813D		17. INFORMATION P.O. Box 599		Address		Allegany County Infirmary Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 S. Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) Chr. A.S.C.V.D. 4227 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Highb C.V.A. = Reptant. Blindness								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yrs 10 yrs			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12/5, 19 67, to 2/19, 19 68, that (I) (we) last saw the deceased alive on 2/19, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. John A. Topper		22c. DATE SIGNED 2/19/68		22d. PHYSICIAN'S NAME (Type) Dr. John A. Topper		22e. ADDRESS Memorial Hospital, Cumberland Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/22/68		23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City or Town) Westernport Md.					
24. FUNERAL DIRECTOR E. J. Boal		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE					

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MINUTE OF MEETING

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01935

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01925

1. DECEASED NAME (Type or Print)		First WALTER	Middle H.	Last LARUE	2a. DATE KNOWN OF DEATH Month Day Year FEB. 5, 1968		2b. DATE PRONOUNCED DEAD Month Day Year FEB. 5, 1968	2c. HOUR 7:30 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JAN. 2, 1899		6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.		
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 91 ORMOND ST.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY CELANESE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 91 ORMOND ST.	
14. FATHER'S NAME First Middle Last ELWOOD LARUE			15. MOTHER'S MAIDEN NAME First Middle Last SARAH RAVENSCROFT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) YES		16b. SOCIAL SECURITY NO. (If no, give year or dates of service) WW 1 214-07-2940		17. INFORMANT ADDRESS MRS. FLOSSIE LARUE, FROSTBURG, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 410.9 (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ---								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED February 5, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 7, 1968		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY		
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR FEB 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

75210

James H. Johnston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the funeral director's office and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01936				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01926					
1. DECEASED-NAME (Type or print) First Middle Last				2a. DATE OF DEATH Month Day Year				2b. HOUR P.M.					
NELLIE M. LEASE				FEBRUARY 18 1968				5:40 PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
FEMALE		WHITE		5-10-1903		64 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.					
W. VA.		U. S. A.				ALLEGANY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND		MEMORIAL HOSPITAL		MD.		RESTURANT							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
MD.		ALLEGANY		CUMBERLAND		YES		947 CUMBERLAND ST.					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
WILLIAM D. LEASE				ANNA LARK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO				215 20 7049		MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy, massive</u> 431.0 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension & arteriosclerosis</u> 331X PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d 3	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/68</u> to <u>2/18/68</u> , that (I) (we) last saw the deceased alive on <u>2/18/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>S. G. Weisman</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/19/68</u>							
22d. PHYSICIAN'S NAME (Type) <u>DR. S. G. WEISMAN</u>				22e. ADDRESS <u>CUMBERLAND, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
BURIAL		FEB 21, 1968		SUNSET MEMORIAL PARK		CUMBERLAND, MD.							
24. FUNERAL DIRECTOR <u>BYRON KIGHT</u>				ADDRESS <u>CUMBERLAND, MD.</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01937				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01927							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR	
Arthur				Lemmert						February 14, 1968		11:30 MA			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		Feb. 10, 1883				85 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
Maryland		U S A				Allegany									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
Frostburg		Miners Hospital		Locomotive Engineer		C & P R R									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
Maryland		Allegany		Mt. Savage		xx		-----							
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last	
Jacob				Lemmert						Elizabeth				Arthur	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address							
No		712-14-1565		Mrs. E. Pickerell				Mt. Savage, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive C-V disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12-17-67</u> <u>?</u> <u>—</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443X</u> <u>Senility</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>12-17</u> , 19 <u>67</u> , to <u>2-14</u> , 19 <u>68</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>2-14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DATE SIGNED													
<u>H.C. Diehl M.D.</u>		<u>2-16-68</u>													
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS													
<u>H.C. Diehl, M.D.</u>		<u>Frostburg, Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)									
Burial		<u>2/17/1968</u>		<u>Frostburg Memorial Park</u>		<u>Frostburg Alleg Md</u>									
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE							
<u>John J. Hafer, Jr.</u>		<u>DATE FEB 19 1968</u>						<u>Charles Jones</u>							

01357

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>01938</div> <div>Item #5 Film #397 2/16/68</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01928</div>																			
1. DECEASED-NAME (Type or Print) PAUL EDWARD LEWIS						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Feb. Day 5 Year 1968						2b. HOUR 7:45 M M							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEB. 3, 1916		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD Month FEB. Day 5 Year 1968		2d. HOUR 8:00 M M					
7a. BIRTHPLACE (State or foreign country) W. Va.				7b. CITIZEN OF WHAT COUNTRY? USA				B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY Md.							
10. CITY OR TOWN OF DEATH LUKE				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRATT ST. EXT.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MERCHANT				12b. KIND OF BUSINESS OR INDUSTRY GROCERY STORE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND						13b. COUNTY ALLEGANY		13c. CITY OR TOWN LUKE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER PRATT ST. EXT.							
14. FATHER'S NAME NICHOLAS LEWIS						15. MOTHER'S MAIDEN NAME IVA PEARL SIMMONS													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown) WW 2				16b. SOCIAL SECURITY NO. 232 09 4474				17. INFORMANT HAZEL NEWMAN				ADDRESS PRATT ST. EXT., LUKE, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 410.9 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. 0 P.M. 0						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Benedict Skitarelic M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 2/5/68							
EXAMINER'S NAME (Type) BENEDIOT SKITARELIO						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						ADDRESS (Street, city, town, or county) Cumberland, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE FEB. 8, 1968				23c. NAME OF CEMETERY OR CREMATORY PARSONS CITY CEMETERY				23d. LOCATION (City or Town) (County) (State) PARSONS W. Va.							
24. FUNERAL DIRECTOR Ed Hall						ADDRESS WESTERNPORT, Md.						25a. REC'D BY REGISTRAR FEB 8 1968				25b. REGISTRAR'S SIGNATURE Charles Judge			

01334

01334

Rembert H. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

01939										MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01929															
Item 13e Film G399 3/27/68 kk										CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First		Middle		Last			2a. DATE OF DEATH				2b. HOUR											
IVAN			I.		LICHENSTEIN			FEB 24 1968				4:00PM													
3. SEX			4. RACE			5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN											
MALE			WHITE			6-12-1889				78 YRS.															
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH															
MARYLAND			USA							ALLEGANY Md.															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY												
CUMBERLAND			MEMORIAL HOSPITAL						PHARMACIST																
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER															
MARYLAND			ALLEGANY			CUMBERLAND		X		CUMBERLAND				Algonquin Hotel CUMBERLAND NURSING HOME											
14. FATHER'S NAME			First		Middle		Last			15. MOTHER'S MAIDEN NAME			First		Middle		Last								
RUBEN					LICHENSTEIN					SARAH					HIRSH										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT																			
						MEMORIAL HOSPITAL, CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Cardiac Failure</i> <i>492X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic lung disease, emphysema, fibrosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ar. arteriosclerosis</i> <i>5277</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>25 Oct. 67</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>occlusion left popliteal artery 19 Oct. 68</i>																									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION			Street or R.F.D. No.			City or Town			County			State						
22a. I certify that (I) (this hospital) attended the deceased from <i>7 Nov. 1967</i> to <i>24 Feb. 1968</i> , that (I) (we) last saw the deceased alive on <i>24 Feb. 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death.																									
22b. SIGNATURE <i>W.A. Van Ormer, M.D.</i>														DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <i>26 Feb. 68</i>			
22d. PHYSICIAN'S NAME (Type)														22e. ADDRESS											
W.A. VAN ORMER, M.D.														122 S. CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)			(County)			(State)										
Burial			Feb. 26, 1968		East View Cemetery				Cumberland			Allegany			Md.										
24. FUNERAL DIRECTOR																									
ADDRESS																									
25a. REC'D BY REGISTRAR																25b. REGISTRAR'S SIGNATURE									
Louis Stein, Inc.																Cumberland, Md.		DATE FEB 28 1968		<i>William J. Jones</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01940		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02089	
1. DECEASED-NAME (Type or print) First Middle Last Fannie Beatrice Long				2a. DATE OF DEATH Month Day Year 2 27 68		2b. HOUR P 2:30 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/27/1879,		6. AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany, Cumberland Md.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last John Gorman		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Wegman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 212-54-8212		17. INFORMANT Allegany County Infirmary Records P.O. Box 599, Cumberland, Md. - Allegany			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Virus Infection</u> 0799 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>gms.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 0969							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 15 1963</u> , to <u>FEBRUARY 27 68</u> , that (I) (we) last saw the deceased alive on <u>February 26 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>George M. Simons</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) George M. Simons				22e. ADDRESS Memorial Hospital Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 1, 1968		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegan, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE MAR 7 1968		25b. REGISTRAR'S SIGNATURE <u>James F. Scarpelli</u>	

03089

03010

11-1-10

[Faint handwritten text, possibly a signature or name]

03089

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
First Middle Last RAYMOND MAC DONALD					FEB 25 Day 68 Year 8:25PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
MALE		WHITE		8-14-03		64 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
PENNA.		U.S.A.				ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL			DISPATCHER		RAILROAD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND				723 GEPHART DRIVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
CHARLES MAC DONALD			JENKINS, ESTHER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			705 10 6905		MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Feb 25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>B. Schindler</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>2-26-68</u>					
22d. PHYSICIAN'S NAME (Type) B. SCHINDLER, M.D.					22e. ADDRESS 69 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		FEB. 28, 1968		SUNSET MEMORIAL PARK		CUMBERLAND, MD.				
24. FUNERAL DIRECTOR BYRON KIGHT ADDRESS CUMBERLAND, MD.					25a. REC'D BY REGISTRAR DATE FEB 29 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

01351

01350

RAYMOND

MAC DONALD

1955-56

01350

MALE

WHITE

8-14-03

1955-56

PENNA.

U.S.A.

ALLEGANY

CUMBERLAND

WATERLOO

ALLEGANY

WATERLOO

125 CYPRESS DRIVE

CHARLES

MAC DONALD

JENKINS

ESTER

TO

VERMONT, CUMBERLAND, MD.

B. SCHWABER, D.D.

25 GREEN ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First TERESA		Middle ANN		Last MALOOFF		2a. DATE OF DEATH Month 2- Day 5 Year 68		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2-2-68			6. AGE (In years lost birthday) YRS. 22		2b. HOUR P 12:45M		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W.VA.			13b. COUNTY MINERAL		13c. CITY OR TOWN FT. ASHBY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER BOX 126		
14. FATHER'S NAME First DONALD Middle M. Last MALOOFF			15. MOTHER'S MAIDEN NAME First LAURA Middle G. Last GEWECKE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 7468 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Convulsions DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7513										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert D. Brodell						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) DR. ROBERT D. BRODELL						22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.					
24. FUNERAL DIRECTOR William G. Kight						25a. REC'D BY REGISTRAR DATE FEB 9 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

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ALLIANCE

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CHURCH AND STATE

OR ROBERT D. BLOOMER

CHATELAIN

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01943

01932

1. DECEASED-NAME (Type or Print) Glenn Edward Miller			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 17 Year 68			2b. HOUR 3:30 P M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 10, 1914	6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS 53	IF UNDER 24 HRS. HOURS 53	2c. DATE PRONOUNCED DEAD Month February Day 17 Year 1968			
7a. BIRTHPLACE (State or foreign country) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miner's Hospital--DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Motor Reader, Town of Grantsville		12b. KIND OF BUSINESS OR INDUSTRY Grantsville		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Clarence Middle Miller Last Miller			15. MOTHER'S MAIDEN NAME First Ida Middle Johnson Last Johnson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 412		17. INFORMANT Mrs. Mary Kelley, Grantsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion, Right DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis, Right DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cardiac Hypertrophy, right; Emphysema, bilateral, Marked.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED February 17, 1968			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/20/68		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett, Md.			
24. FUNERAL DIRECTOR Lush Newman				ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR FEB 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01944												01933																			
DIVISION OF VITAL RECORDS												301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
Item 15 Film G398 2/28/68 kk												CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)				First JOHN				Middle MILLER				Last MILLER				2a. DATE OF DEATH Month FEBRUARY				Day 4				Year 1968				2b. HOUR 6:58			
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH SEPT. 23, 1906				6. AGE (In years last birthday) 61				IF UNDER 1 YEAR MONTHS 0				DAYS 0				IF UNDER 24 HRS. HOURS 0				MIN. 0			
7a. BIRTHPLACE (State or foreign country) CHECHOSLOVAKIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY								Md.											
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN CUMBERLAND				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 310 RACE STREET															
14. FATHER'S NAME First JOHN				Middle MILLER				Last MILLER				15. MOTHER'S MAIDEN NAME First ANNA				Middle Chisar				Last Chisar											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT MEMORIAL HOSPITAL,								Address CUMBERLAND, MD.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163X																															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from Sept 23, 1906 , to 2/4 , 19 68 , that (I) (we) last saw the deceased alive on 2/3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																															
22b. SIGNATURE S. G. Weisman				DEGREE S. G. Weisman				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 2/5/68																			
22d. PHYSICIAN'S NAME (Type) S. G. Weisman				22e. ADDRESS Cumberland, Md.																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 2/8/68				23c. NAME OF CEMETERY OR CREMATORY Braddock Cemetery				23d. LOCATION (City or Town) (County) (State) Rankin, Penna.																			
24. FUNERAL DIRECTOR Philip B. Wendt				ADDRESS 121 Memorial Ave. Cumb., Md.				25a. REC'D BY REGISTRAR DATE FEB 7 1968				25b. REGISTRAR'S SIGNATURE [Signature]																			

01234

01233

1958 FEB 1

FEBRUARY

WILLER

JOHN

SEPT. 23, 1906

WHITE

WIFE

ALLIANCE

CHICAGO, ILL.

CUMBERLAND, MD. MEMORIAL HOSPITAL

210 RACE STREET

ALLEGANY CUMBERLAND, MD.

ANNA WILLER

WILLER

JOHN

CUMBERLAND, MD. MEMORIAL HOSPITAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

01945 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01934			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b. HOUR OF ESTI-DEATH MATED <input type="checkbox"/> Feb. 23, 19 68 3:20A		
Russell			Moon										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male		White		7/24/1892		75 YRS.		MONTHS		DAYS		2d. HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland				Memorial Hospital				Retired Textile Worker				Celanese	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Allegany		La Vale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		314 National Highway			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME			
George				W.		Moon				Lucretia A. Savage			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Md.			
Yes				WW 1		214-07-0698		Mrs. Elizabeth B. Moon, 314 Nat'l Hwy LaVale					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:										sudden			
IMMEDIATE CAUSE (a)													
441.9 SHOCK													
DUE TO, OR AS A CONSEQUENCE OF													
(b) HEMORRHAGE										3 hours			
DUE TO, OR AS A CONSEQUENCE OF													
(c) RUPTURED ANEURYSM										"			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
451X													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
February 23, 1968				Aortic Aneurysm				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
CAUSE OF DEATH				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				Benedict Skitarelic				M.D.					
EXAMINER'S NAME (Type)				Benedict Skitarelic, M.D.				22b. DATE SIGNED					
								Feb. 23, 1968					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial				2/25/1968		North Glade Cemetery		Near Swanton Garrett Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John J. Hafer, Jr., 230 Balto Ave., Cumberland Md.								FEB 27 1968		Charles Judge			

2210

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11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01946

Item 15 Film G397 2/14/68 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01935

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
LULA		R.	MYERS	FEBRUARY		1968 05			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 1/25/1882		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U.S.A.				ALLEGANY COUNTY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		Own Home	
CUMBERLAND, MD.		MEMORIAL HOSPITAL		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND, S				509 E. FIRST ST. CUMB., MD.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
NIMROD			LITTLE	HUFF,	SAVOTTA/ Zalotta				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				MEMORIAL HOSPITAL, CUMBERLAND MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)	
4319				Massive Cerebral Hemorrhage		7 days		5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
331X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1966 to July 1, 1968, that (I) (we) last saw the deceased alive on July 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Clark J. Durrett								2/2/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
DR. C.E. DURRETT		236 VIRGINIA AVENUE, CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Feb. 3, 1968		Rose Hill Cemetery		Cumberland		Allegany Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.		DATE FEB 8 1968		Charles Judge					

01554

01555

MEMORIAL OF DEATH

DATE OF DEATH FEBRUARY 1 1968

AGE 1 1/2 YEARS

SEX X

CHURCHLAND, E. MEMORIAL HOSPITAL

ALLICARY, CONFESSION

WIFE, CAROL

MEMORIAL HOSPITAL, CONFESSION



DR. E. F. BURBETT 236 / 18011A AVENUE, CHURCHLAND, NM

RECEIVED
FEB 1 1968
FBI - ALBUQUERQUE
FBI - MEMPHIS
FBI - JACKSONVILLE
FBI - TAMPA
FBI - MIAMI
FBI - ORLANDO
FBI - FORT LAUDERDALE
FBI - MIAMI BEACH
FBI - PALM BEACH
FBI - WEST PALM BEACH
FBI - BOCA RATON
FBI - FORT MYERS
FBI - SAN PETERSBURG
FBI - VENICE
FBI - CLEARWATER
FBI - DUNEDIN
FBI - PALM SPRING
FBI - WEST PALM BEACH
FBI - BOCA RATON
FBI - FORT MYERS
FBI - SAN PETERSBURG
FBI - VENICE
FBI - CLEARWATER
FBI - DUNEDIN
FBI - PALM SPRING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01947
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01936

1. DECEASED-NAME (Type or print) LORETTA V. NEVY			2a. DATE OF DEATH Month February Day 11 Year 1968			2b. HOUR 5:18 PM						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-20-27		6. AGE (In years lost birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 		
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 825 HARVARD AVE.			
14. FATHER'S NAME First LAWRENCE Middle Last TOEPFER			15. MOTHER'S MAIDEN NAME First MARY Middle Last MYERS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-24-8592		17. INFORMANT HOSP. RECORD			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Petroleum Cell Sarcoma 2000 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 2000												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 								
22a. I certify that (I) (this hospital) attended the deceased from 12/5 , 19 67 , to 3/11 , 19 68 , that (I) (we) last saw the deceased alive on 3/11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE J. A. PAGAN, M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/12/68								
22d. PHYSICIAN'S NAME (Type)		J. A. PAGAN, M.D.		22e. ADDRESS 5 POTOMAC ST., RIDGELEY, W. VA.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 14, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.						
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE FEB 15 1968		25b. REGISTRAR'S SIGNATURE Richard Judge						

MEDICAL CERTIFICATION

01034

01234

LORETTA	WHITE	11-20-37	NO	FEBRUARY 11, 1967
CHIC	USA	X	ALLEGY	
CHARLENE, MD.	SACRED HEALT HOSP.		HOMELIFE	
MD.	ALL-GAY	CHARLENE X	SS HARVARD	
LAVERICE	TOEPFER	LADY	214-24-292	214-24-292
	214-24-292	HOSP. RECORD		

J. V. PACAR, M.D. 2 TOTTEN ST., DORCHESTER, MA.

01034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01948									
01937									
1. DECEASED-NAME (Type or print)			First Middle Last GREGORY DENNIS NIXON			2a. DATE OF DEATH Month Day Year FEB 26 1968		2b. HOUR 12:50 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH NOV 21, 1939		6. AGE (In years last birthday) 28 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) CUMBERLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PITTSBURGH PLATE GLASS COMPANY		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CAVALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 737 VALLEY VIEW DRIVE	
14. FATHER'S NAME First Middle Last HARRY JOSEPH NIXON			15. MOTHER'S MAIDEN NAME First Middle Last HELENE C. EIRICH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) 1963-1968		16b. SOCIAL SECURITY NO. 219-34-5917		17. INFORMANT Address MRS DOROTHY NIXON 737 VALLEY VIEW DRIVE LAVALE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Astrocytoma, third ventricle</u> 1920 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 mos									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1930									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HDW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1.15.67</u> , 19 <u> </u> , to <u>2.26.68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2.26.68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William P. James, M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2.27.68			
22d. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22e. ADDRESS 441 N. CENTRE ST. CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL, ETC. BURIAL		23b. DATE 29 FEB 68		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND ALLEGANY MD.			
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST CUMBERLAND MD.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 29 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

0103

23216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01949

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G398 3/7/68 kk

CERTIFICATE OF DEATH

01938

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Lena			Lurittia	Oester	Feb. 25, 1968			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		Nov. 22, 1901		67 66 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W.Va.		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Frostburg			Miner's Hospital			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Garrett		Grantsville						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Franklin			Margaret		Crowfis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No					George Oester, Grantsville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE BRAIN SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CIRCULATORY DISTURBANCE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRAL ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 6 days 8 YRS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 334X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan. 27, 1968, to Feb. 25, 1968, that (I) (we) last saw the deceased alive on Feb. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G Paige Strong						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2/26/68		
22d. PHYSICIAN'S NAME (Type) A. Paige Strong, M.D.						22e. ADDRESS Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2/29/68		Grantsville Cem.			Grantsville, Garrett, Md.			
24. FUNERAL DIRECTOR Kath Newman						ADDRESS Grantsville, Md.			25a. REC'D BY REGISTRAR DATE MAR 4 1968		
									25b. REGISTRAR'S SIGNATURE Charles Judge		

Cerebral arteriosclerosis
 9 yrs
 Circulatory disturbance
 6 days
 Acute Brain Syndrome

2 Page History
 2/25/68
 10. 25. 68 Jan 27 to Feb 25 68

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01950

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01939

1. DECEASED-NAME (Type or Print)		First JAY	Middle IRVIN	Last OSTER	2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day 2 Year 26		2b. HOUR 2:30 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JAN. 14, 1910		6. AGE (in years last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 2 Day 26 Year 1968	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 309 DECATUR ST.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY BAKERY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.		13b. COUNTY BEDFORD		13c. CITY OR TOWN RFD BEDFORD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER ROUTE 3,	
14. FATHER'S NAME First T. Middle H. Last OSTER		15. MOTHER'S MAIDEN NAME First AURORA Middle BOOR Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			
16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT MARGARET E. OSTER, ROUTE 3, BEDFORD, PA.		17. ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED FEB. 26, 1968	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CUMBERLAND, MD.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 29, 1968		23c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		CUMBERLAND, MD.		25a. REC'D BY REGISTRAR FEB 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

01234

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01234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

01951										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01940									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First MIDDLE Last HARRY WILLIAM POLAND										FEB. Month 10, Day 1968 Year										M									
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH NOV. 6, 1901			6. AGE (In years last birthday) 66 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.																	
10. CITY OR TOWN OF DEATH D.O.A. CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SERVICE STATION OWNER			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN MT. SAVAGE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
14. FATHER'S NAME First Middle Last THOMAS P. POLAND					15. MOTHER'S MAIDEN NAME First Middle Last MARTHA S. HENCKEL																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-32-3213			17. INFORMANT MRS. MARGARET B. POLAND, MT. SAVAGE, MD.			Address																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion - Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from Oct 1962, to Feb 1968, that (I) (we) last saw the deceased alive on Feb 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>O. G. Himmelwright</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2/12/68																							
22d. PHYSICIAN'S NAME (Type) DR. O. G. HIMMELWRIGHT			22e. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.																										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE FEB. 13, 1968			23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEMETERY			23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.																				
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532			25a. REC'D BY REGISTRAR DATE FEB 15 1968			25b. REGISTRAR'S SIGNATURE <i>John Judge</i>																							

01210

01210

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10/10/2001 BY 60322 UCBAW/SJS/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>01952</div> <div> <div>01941</div> <div>01941</div> </div>															
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR			
WILLIAM M. POPP								FEBRUARY 3, 1968				9:10			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 1 YEAR			
MALE		WHITE		5-29-96				71 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH							
MD.		U. S. A.		WIDOWED		DIVORCED		ALLEGANY Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND				MEMORIAL HOSPITAL				Retired Production				Textile			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MD.				ALLEGANY		CUMBERLAND		YES NO		RT 2 WILLIAMS RD.					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
First Middle Last				First Middle Last											
LEWIS POPP				EMILY WILT											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
no						MEMORIAL HOSPITAL, CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Carcinoma of liver.</u>												<u>One</u>			
DUE TO, OR AS A CONSEQUENCE OF (b)												<u>Month</u>			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
1561															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
								YES NO							
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)				HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
While at work Nat while at work															
22a. I certify that (I) (this hospital) attended the deceased from 1-2-1968, to 2-5-1968, that (I) (we) last saw the deceased alive on 2-5-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												22c. DATE SIGNED			
DR. W. F. WILLIAMS												2-5-68			
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS			
CUMBERLAND, MD.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				Feb. 6, 1968		Sunset Memorial Park				Cumberland Allegany Md.					
24. FUNERAL DIRECTOR ADDRESS												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.												DATE FEB 8 1968		Charles Judge	

01228

01221

FEBRUARY 3, 1968 8:10

PORT

WILLIAM

MALE

WHITE

F-52-36

191

NO.

U. S. A.

ALLEGANY

CHUBBAND

HOSPITAL

ST 2 WILLIAMS RD.

CUMBERLAND

ALLEGANY

LEWIS

PORT

EMILY

WILL

MEMORIAL HOSPITAL, CHUBBAND, MD.

DR. W. F. WILLIAMS

CHUBBAND, MD.

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1 M

01953

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01942

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
DARRELL		J.		RACEY	Month	Day	Year	11:40 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		WHITE		7-29-09-1889		78 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
WEST VIRGINIA		U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		Policeman		Municipal			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				15 W. SECOND ST.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
JAMES				RACEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				MEMORIAL HOSPITAL		CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> 185X DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Prostate</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinomatous</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Acute</i> 3 yrs 10 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 177X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 10, 1967</i> , to <i>Feb 9, 1968</i> , that (I) (we) lost saw the deceased alive on <i>Feb 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
<i>Clay Durrett</i>		<i>2/10/68</i>		DR. CLAY DURRETT					
22e. ADDRESS		22f. ADDRESS							
CUMBERLAND, MD.		CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 12, 1968		Hillcrest Burial Park		Cumberland Allegany Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.				DATE		<i>FEB 13 1968</i>			

01954

01945

01940

RACE

J.

DARRELL

WHITE

AGE

ALLBANY

U.S.A.

WEST VIRGINIA

GENERAL HOSPITAL

CLEVELAND

15 W. SECOND ST.

CLEVELAND

ALLBANY

RACE

JAMES

GENERAL HOSPITAL

CLEVELAND

DR. CLAY DUNNETT

CLEVELAND

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH																				
1. DECEASED-NAME (Type or print)			First THOMAS			Middle GEORGE			Last REED			2a. DATE OF DEATH Month FEBRUARY Day 5 Year 1968			2b. HOUR 8:15 P.M.					
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 11-4-1912			6. AGE (In years lost 55 day)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY						Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY CELANESE								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER P. O. BOX 433								
14. FATHER'S NAME			First CHARLES			Middle REED			15. MOTHER'S MAIDEN NAME			First MYRTLE			Middle FLEEGLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Merchant Marine WW2			16b. SOCIAL SECURITY NO. 2 17-10-4310			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>410.9 Congestive heart failure with pulm. failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction, antero-septal</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease with myocardial infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>24 hours</i> <i>30 may 1966</i>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>acute upper Resp. Infection 3 weeks</i> <i>Diabetic Prone 15 months</i>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION			Street or R.F.D. No.			City or Town			County			State		
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 1966, to <i>5 Feb.</i> , 1968, that (I) (we) last saw the deceased alive on <i>5 Feb.</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>W.A. Van Ormer</i>			22c. DATE SIGNED <i>6 Feb. 68</i>																	
22d. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER			22e. ADDRESS CUMBERLAND, MD.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE Feb. 8, 1968			23c. NAME OF CEMETERY OR CREMATORY Mt. Savage Methodist			23d. LOCATION (City or Town)			(County)			(State) MD.					
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pennsylvania			25a. REC'D BY REGISTRAR FEB 13 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>														

01954

01954 2.1

FEBRUARY 2, 1968 8:13

REED

GEORGE

THOMAS

MALE

WHITE

11-1-1912

ALLEGANY

MARYLAND U. S. A.

CUMBERLAND MEMORIAL HOSPITAL

02-14-528

P. O. BOX 433

MARYLAND ALLEGANY M. SAVAGE

CHURCHES

REED

MYRTLE

FLEECE

CUMBERLAND, MD. 11-1-1912 MEMORIAL HOSPITAL

CUMBERLAND, MD.

DR. W. A. VAN ORMER

FOR S. 1968 M. SAVAGE MARYLAND U. S. A.

MARYLAND ALLEGANY M. SAVAGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First GLADYS			Middle PEARL			Last RICE			2a. DATE OF DEATH FEBRUARY Day 1 , Year 1968			2b. PM 9:30		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 3-12-1907			6. AGE (In years last birthday) 60 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) PENN.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY Own home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 203 FIFTH ST.					
14. FATHER'S NAME First WILLIAM			Middle E.			Last GOLDEN			15. MOTHER'S MAIDEN NAME First MARY			Middle ELIZABETH			Last SMITH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident-Brain Stem 2509 DUE TO, OR AS A CONSEQUENCE OF Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic-arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF Disease (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days Years																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to Feb. , 19 1968 that (I) (we) last saw the deceased alive on Feb. 1 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE DR. G. O. HIMMELWRIGHT			DEGREE DR.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Feb. 2, 1968								
22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT			22e. ADDRESS CUMBERLAND, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/4/68			23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery			23d. LOCATION (City or Town) (County) (State) nr. Cumberland, Allegany Md.								
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland			ADDRESS			25a. REC'D BY REGISTRAR DATE FEB 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

0125

SPEC

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

01956		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01945	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH	
KENNETH			S.		BITTER	FEBRUARY Month 9 Day 1968 Year 2:40PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
MALE		WHITE		8-11-07		60 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
VIRGINIA		U.S.A.				ALLEGANY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART		Security Guard		AUTO TIRE CO.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		ALLEGANY		LA VALE		13e. STREET AND NUMBER	
						16 PARKSIDE BLVD.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME	
HARRY			E		BITTER	ALICE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		
NO			214-05-9981		HOSPITAL RECORD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-2-1968, to 2-9-1968, that (I) (we) last saw the deceased alive on 2-9-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED					
L. Brings		2-9-68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
LEWIS BRINGS, M.D.		57 GREEN ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		2/12/68		Reddown Memo Ph.		Cumberland, Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
LOUIS STEIN INC. 117 FREDERICK ST., CUMB.MD.		DATE FEB 13 1968		James J. Stein			

01222

KENNETH 2 BITTER FEBRUARY 9 1966 2:40P

WHITE 6-11-67 60

U.S.A. X ALLEGANY

CONBERLAND SACRED HEART AUTO TIRE CO

MARYLAND ALLEGANY LA ALE 12 PARKSIDE BLVD

HARRY BITTER ALICE HARRY

214-02-3031 HOSPITAL RECORD



LEWIS BRINGS, M.D. 27 GREEN ST., CHAMBERLAND, MD. 21022

LEWIS STEIN, INC. 117 FREDERICK ST., CHAMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JOHN		F.		ROSE		FEBRUARY 3, 1968		10:15 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 1 YEAR	
MALE		WHITE		10-26-1894		73 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD.		U. S. A.				ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		MEMORIAL HOSPITAL		Publisher		Paper					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
W. VA.		Mineral		PIEDMONT				34 E. FAIRVIEW ST.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
FRANK		W.		ROSE				ELIZA		J. PEARCE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes		W.W. I		233-50-3709		MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic vas. dish 2 hours</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Long advanced Coronary artery dis.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>About</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1-20-68</u> , to <u>2-3-68</u> , that (I) (we) last saw the deceased alive on <u>2-3-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<u>W.F. Williams</u>		<u>2-5-68</u>		DR. W. F. WILLIAMS		CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		2/7/68		Philos Cemetery		Westernport All. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. Harold Fredlock, Jr.		Piedmont, W. Va		DATE FEB 8 1968		<u>William J. Judge</u>					

01955

01955

NAME: WHITE
 DOB: 10-26-1894
 SEX: M
 RACE: WHITE
 ETHNICITY: ALLEGANY

CURRENT ADDRESS: 34 E. FAIRVIEW ST., CUMBERLAND, MD.
 PREVIOUS ADDRESS: 1000 E. FAIRVIEW ST., CUMBERLAND, MD.
 EMPLOYER: ROSE, ELIZA
 OCCUPATION: W. VA.

DR. W. A. WILLIAMS
 CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

01958				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01947					
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR		
NORMAN				Bruen	SCHILLER		Feb. 13 68				7:20AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE		WHITE		2-6-81			87 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.	
PENNSYLVANIA		U.S.A.				ALLEGANY							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND			MEMORIAL HOSPITAL			RETIRED			Carpenter				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
MD.			ALLEGANY		CUMBERLAND				630 FAIRVIEW AVENUE				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
JOHN				SCHILLER		MARGARET				Weinhold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
NO			217-10-4966A			MEMORIAL HOSPITAL			CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Rupture Abd. Aortic Aneurysm</u> 4412 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 451X <u>Chronic congestive Heart Failure</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from Nov 1964 to 2-13 1968, that (I) (we) last saw the deceased alive on 2-13 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>William P. James</u>			22c. DATE SIGNED 2/15/68			22d. PHYSICIAN'S NAME (Type) DR. W. P. JAMES			22e. ADDRESS CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			2-16-68		Sunset Memorial Park			Cumberland Allegany Maryland					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE FEB 19 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
Dale L. Merritt 404 Decatur St., Cumb., Md.													

740 FC

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First MARY		Middle G.	Last SETTLE	2a. DATE OF DEATH Month FEBRUARY Day 7, Year 1968	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8-6-02		2b. HOUR 8:30	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HWFE.		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First WALTER		Middle BRADY		Last MARY		15. MOTHER'S MAIDEN NAME First E Middle HOFFMAN Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (b) Myocarditis & Decomposition DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 8 wks 5 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 260x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on June 6, 1966 , to Feb 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Clayton Jurett DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 2/8/68			
22d. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT				22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb. 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR FEB 13 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

01200

01200

WALTER	BRADY	BRADY	WALTER	WALTER	WALTER
MD.	ALLEGANY	ALLEGANY	ALLEGANY	ALLEGANY	ALLEGANY
CUMBERLAND	CUMBERLAND	CUMBERLAND	CUMBERLAND	CUMBERLAND	CUMBERLAND
U.S.A.	U.S.A.	U.S.A.	U.S.A.	U.S.A.	U.S.A.
WHITE	WHITE	WHITE	WHITE	WHITE	WHITE
8-6-32	8-6-32	8-6-32	8-6-32	8-6-32	8-6-32
SETTLE	SETTLE	SETTLE	SETTLE	SETTLE	SETTLE
FEBRUARY 7, 1963 8:30	FEBRUARY 7, 1963 8:30	FEBRUARY 7, 1963 8:30	FEBRUARY 7, 1963 8:30	FEBRUARY 7, 1963 8:30	FEBRUARY 7, 1963 8:30

DR. CLAY DURETT

CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> 01960 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01949 </div>											
1. DECEASED-NAME (Type or print) ARTHUR L. SIEBERT				2a. DATE OF DEATH Month 2 Day 28 Year 68				2b. HOUR 12:15			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-13-1910				6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS 5 DAYS 10	
7a. BIRTHPLACE (State or foreign country) CUMBERLAND, MD		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bartender				12b. KIND OF BUSINESS OR INDUSTRY Thayers Barn	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 231 GLENN ST.,			
14. FATHER'S NAME First Middle Last GEORGE A SIEBERT				15. MOTHER'S MAIDEN NAME First Middle Last IDA A. KERNS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-07-0479		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.					
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lung 162.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163 X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1968 , to July 28, 1968 , that (I) (we) lost saw the deceased alive on July 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 2-29-68			
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER				22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md.					
24. FUNERAL DIRECTOR John J. Hafer, Jr.				25a. REC'D BY REGISTRAR DATE MAR 4 1968		25b. REGISTRAR'S SIGNATURE [Signature]					

01548

01548

ARTHRUR
WIFE
CUMBERLAND, D. A.
ALLGARY

GENERAL HOSPITAL
WARTON
GENERAL HOSPITAL
WARTON

GENERAL HOSPITAL
WARTON

GENERAL HOSPITAL
WARTON

GENERAL HOSPITAL
WARTON

GENERAL HOSPITAL
WARTON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is unnecessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

013544

VR A15ME (S)
10M REV. 1/68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01962

01951

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A.M. P.M.			
LILLIAN MAY SNYDER						FEBRUARY 24, 1968			11:45			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
FEMALE		WHITE		MARCH 12, 1903			64					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
MT. SAVAGE, MD.		U.S.A.					ALLEGANY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
FROSTBURG		MINEERS HOSPITAL			HOUSEWIFE			OWN HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
MARYLAND		ALLEGANY		R.F.D. 1				MT. SAVAGE BOX 62, R.F.D. 1				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
CHARLES CROWE						CLARA SWEENE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address								
NO N.A.		NONE		MRS. NAOMI STEWART, MT. SAVAGE, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Vulva</u> 1841 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1760 NONE												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
NONE												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from June, 1967, to 2/24, 1968, that (I) (we) last saw the deceased alive on 2/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
MARTIN M. ROTHSTEIN, M.D.										2/25/68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
MARTIN M. ROTHSTEIN, M.D.						48 BROADWAY, FROSTBURG, MD. 21532						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL		FEB. 27, 1968		MT. SAVAGE METH. CEM.			MT. SAVAGE, ALLEGANY MARYLAND					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
MARILOU M. SOWERS				HOME, 60 W. MAIN, FROSTBURG				FEB 29 1968		James Judge		

01221

01221

EXHIBIT OF CASE

RECEIVED
JAN 12 1968
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM
TO : DIRECTOR
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

[Extremely faint and mostly illegible body text of the memorandum, appearing as horizontal lines across the page.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01963

01952

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b. HOUR	
JOHN			ALEXANDER	STEHLLEY	FEB			17	1968	8:30P			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
MALE	WHITE	DEC 27, 1889	78 YRS.					FEB		17	1968	8:30P	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.							
WEST VIRGINIA		U.S.A.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND MD.			D.O.A. MEMORIAL HOSPITAL			RETIRED DENTIST			DOCTOR				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
MARYLAND			ALLEGANY		CUMBERLAND				502 FREDERICK STREET				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
FRAZER			P.	STEHLLEY	MARTHA	ELLEN	AVIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS								
NO			212-38-6214-A		MRS MARTHA STEHLEY 502 FREDERICK ST. MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ----	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <u>4201</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				FEB. 17, 1968					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL			FEB 20 1968		SUNSET MEMORIAL PARK			CUMBERLAND ALLEGANY MARYLAND					
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST CUMBERLAND, MD.					25a. REC'D BY REGISTRAR DATE FEB 20 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

01324

01324

01324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

01964										01953									
MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. A.M. or P.M.			
THEODORE		W.		SWANGER				2		23		68		8:00		A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		MONTHS		DAYS		IF UNDER 24 HRS.		HOURS			
MALE		WHITE		4-30-1919		48		YRS.						HOURS		MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH													
MARYLAND		ALLEGANY				ALLEGANY										Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY													
CUMBERLAND		MEMORIAL HOSPITAL		Maintenance		Textile													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER											
MARYLAND		ALLEGANY		CUMBERLAND				RT. #4, IRONS MT.											
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last					
CHARLES				SWANGER				LUCY				SIRBAUGH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address													
yes		War II		MEMORIAL HOSPITAL - CUMBERLAND, MD.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Metastatic Carcinoma - Adenocarcinoma 1890 DUE TO, OR AS A CONSEQUENCE OF Renal in Origin Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1890																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-16 w ks.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from Jan., 19 68, to Feb., 19 68, that (I) (we) last saw the deceased alive on Jan. 22, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																			
22b. SIGNATURE		22c. DATE SIGNED		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS																	
DR. G. O. HIMMELWRIGHT		133 VIRGINIA AVE., CUMBERLAND, MD.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)													
Burial		Feb. 26, 1968		Davis Memorial Cemetery		Cumberland, Allegany, Md.													
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
James F. Scarpelli, Cumberland, Md.				DATE FEB 27 1968		Charles Judge													

01886

01884

THEODORE W. SWANSON

WIFE WHITE P-30-1910

MARYLAND ALLEGANY

CUMBERLAND

MARYLAND ALLEGANY

CHARLES SWANSON

CUMBERLAND

ALLEGANY

ALLEGANY

ALLEGANY

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-113. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01965

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01954

1. DECEASED-NAME (Type or Print)		First		Middle		Last		20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year				2b. PM			
KATHERINE		THOMAS						Feb. 24, 1968				7:00			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD				2d. HOUR		
Female	White	10-10-73		94 YRS.	MONTHS		DAYS		February 24, 1968				PM		
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							Md.		
Maryland		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
Cumberland		Memorial Hospital		Home											
130a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
Maryland		Allegany		Cumberland				413 Franklin Street							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Thomas		Bath						Elizabeth Warne							
160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
				Memorial Hospital, Cumberland, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4129</u> Chronic Myocarditis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) --- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4221</u> Fracture of left femur															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
CAUSE OF DEATH		1:00PM 2-2-68		Fell out of bed at home											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
		Home		413 Franklin Street, Cumberland, All. Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		ADDRESS (Street, city, town, or county)		Cumberland, Md.									
230. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
BURIAL		FEB. 28, 1968		FROSTBURG MEM. PARK		FROSTBURG		ALLEGANY, MD.							
FUNERAL DIRECTOR		MARTLOU M. SOWERS		ADDRESS		HOME, 60 W. MAIN, FROSTBURG		250. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
								FEB 29 1968		Charles Jones					

SERIC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01966

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01955

1. DECEASED-NAME (Type or print)		First JOHN		Middle FRED		Last VALENTINE		2a. DATE OF DEATH February 19, 1968		2b. HOUR 3:25 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH October 21, 1903		6. AGE (In years lost birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tube Operator		12b. KIND OF BUSINESS OR INDUSTRY Kelly Tire					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LAVALLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1243 BRADDOCK ROAD			
14. FATHER'S NAME First JOHN		Middle F.		Last VALENTINE		15. MOTHER'S MAIDEN NAME First MINNIE		Middle C.		Last WILSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-10-6503		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4501</u> (b) <u>Cholesterol Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5-2</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-2	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Major Surgery for Malnutrition & Cachexia</u>											
19a. DATE OF OPERATION 2-9-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma prostate		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <u>122 So. Centre Street, Cumberland, Md.</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/7/68</u> , 19 <u>68</u> , to <u>2/9/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/9/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. J. Williams</u>		22c. DATE SIGNED 2/20/68		22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22e. ADDRESS 122 SO. CENTRE STREET, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/21/68		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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DEPARTMENT OF HEALTH
FEBRUARY 19 1968 3:2

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WYLAND ALLEGANY AVENUE

JOHN A. VALENTINE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A(15)
30M REV. 1/68

M 01967										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01956																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										M																																							
Leonard A. Warnick										2 5 68																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Male										White										3/31/1889										78 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										U.S.A.																				Allegany										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Barton "Rural"																				Retired Miner																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Md										Allegany										Barton "R"																																							
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
Henry Warnick										Mary Dawson																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT Address																																							
																				Mrs. Lola Warnick Barton, Md.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Coronary Occlusion										DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency										years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized Atherosclerosis										DUE TO, OR AS A CONSEQUENCE OF										years																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Jan. 20, 1968, to Feb 5, 1968, that (I) (we) last saw the deceased alive on Jan. 20, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE L.R. Miles, Jr. M.D.										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 2.6.68																																							
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.										22e. ADDRESS LONA CONING, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										2/8/1968										Laurel Hill Cemetery										Moscow A. Md																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
George Eichhorn										Lonaconing, Md.										DATE FEB 13 1968										Charles Judge																													

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OFFICE OF THE

UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>01968</div> <div> <div>01957</div> <div> <div>MD</div> <div>1</div> </div> </div> <div> <div> <div>3</div> <div>4</div> </div> <div> <div>5</div> <div>6</div> </div> </div> <div> <div>7</div> <div>8</div> </div> <div> <div>9</div> <div>10</div> </div>											
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Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
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MEDICAL CERTIFICATION

01969		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01958							
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR					
H. Henry		RALPH WILLIAMS		FEBRUARY 25, 1968		12:40					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		MARCH 27, 1896		77 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND, MD.		MEMORIAL HOSPITAL		DENTIST							
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND		<input checked="" type="checkbox"/> NO <input type="checkbox"/>		38 N. LIBERTY STREET			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
HARRY		WILLIAMS		NELLIE		WHITE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes, no, or (unknown)				MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Transitional cell CA of bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Post</u> 15yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
15yrs.		Ca of bladder		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 2-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
DR/ W/F. WILLIAMS		2/25/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
DR/ W/F. WILLIAMS		122 SO. CENTRE STREET, CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		2/27/68		Monocacy		Beallsville Montg. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William B. Hilton		Beallsville Md.		DATE MAR 1 1968		Charles Judge					

01862

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NAME: WILLIAM RALPH

DATE: MARCH 27, 1946

ALLEGEDLY

U.S.A.

MEMORIAL HOSPITAL

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<div style="display: flex; justify-content: space-between;"> 01970 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01959 </div>											
1. DECEASED-NAME (Type or print) First Middle Last LUCRETIA ADELAIDE WILLIAMS						2a. DATE OF DEATH Month Day Year FEBRUARY 21 1968			2b. HOUR 5:45 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2-27-1890			6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS 77		IF UNDER 24 HRS. HOURS MIN. 45 00
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HWFE.			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 604 MONTREAL AVENUE	
14. FATHER'S NAME First Middle Last MIDDLETON B LUBER				15. MOTHER'S MAIDEN NAME First Middle Last DURETTA LUBER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF Thrombosis (b) Immediate DUE TO, OR AS A CONSEQUENCE OF Had 2 previous attacks & cerebral aneurysm (c) Had 2 previous attacks & cerebral aneurysm PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 42201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 122 S. CENTRE ST., CUMBERLAND, MD.							
22a. I certify that (I) (this hospital) attended the deceased from 2/20/68 to 2/23/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DR. R. J. WILLIAMS						22c. DATE SIGNED 2/23/68		22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE FEB 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MEMBERSHIP LIST

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>01971</div> <div>MDARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>01950</div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
CHARLES H. WINCE						FEBRUARY 10, 1968			7:51 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE		WHITE		7-7-93			74 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
W. VA.		U.S.A.					ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL			Laborer			State Road		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
W. VA.			Hampshire			POINTS				Rural	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
HENRY WINCE			LUCY WAGONER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No			216-22-6995			MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Electrolyte Imbalance</u>										6 days	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <u>Bilateral Ureteral Obstruction</u>										?	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Far Advanced Carcinoma - Bladder</u>										?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
1810											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2/5/68			Ureterostomy in situ			Relieve YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year			obstruction					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State		
White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>2/3/</u> 19 <u>68</u> , to <u>2/10/</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/10/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
Walter N. Himmler MD			2/12/68								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
WALTER HIMMLER, MD.			412 N. MECHANIC ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Feb. 13, 1968			Wesley Chaple			Points, Hampshire W. Va.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Romney, W. Va.						DATE FEB 16 1968			Charles Judge		

01911

01911

CHARLES H. WINCE FEBRUARY 10, 1962 7:51P

WHITE 7-1-62

U.S.A. ALLEGANY

CUMBERLAND REGIONAL HOSPITAL

W.VA. POINTS

HENRY WINCE LUCY WAGONER

REGIONAL HOSPITAL, CUMBERLAND, W.VA.

W.VA.

W.VA.

W.VA.

W.VA.

W.VA.

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W.VA.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

<div>01972</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>01961</div>																							
1. DECEASED-NAME (Type or print)			First GEORGE			Middle Arthur			Last WOLFORD			2a. DATE OF DEATH Month FEBRUARY			Day 7			Year 1968			2b. HOUR 5:30 AM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 8-27-1887			6. AGE (in years last birthday) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.														
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Butcher			12b. KIND OF BUSINESS OR INDUSTRY Grocery														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 415 PULASKI STREET											
14. FATHER'S NAME First Samuel			Middle WOLFORD			Last WOLFORD			15. MOTHER'S MAIDEN NAME First MARY			Middle SCHLUNT			Last SCHLUNT								
16a. WAS DECEASED EVER Yes, no, or (unknown) Yes			16b. SOCIAL SECURITY NO. 214-05-7964			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured femoral aneurysm</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4500																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 10-24, 1966, to 3-7, 1968, that (I) (we) last saw the deceased alive on 3-6-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Charles J. Vance MD												22c. DATE SIGNED 2-9-68											
22d. PHYSICIAN'S NAME (Type) BRADDOCK MEDICAL GROUP						22e. ADDRESS 126 N. SMALLWOOD ST., CUMB. MD.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Feb. 9, 1968			23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.														
24. FUNERAL DIRECTOR H. Wayne George, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE FEB 13 1968			25b. REGISTRAR'S SIGNATURE Charles Judge														

01533

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GEORGE

WOLFORD

FEBRUARY 7 1965

2:30

WEE

WHITE

8-27-1967

80

CH. BERLAND, MD. USA

ALL EMBRY

CUMBERLAND, MD.

GENERAL HOSPITAL

WOLFORD

ALL EMBRY CUMBERLAND, MD.

415 P. 1st STREET

WOLFORD

MARY

SCHEUNY

GENERAL HOSPITAL, CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01973										01962									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH									
First Middle Last										Month Day Year									
CLARA LOUISE ZIMMERLA										FEBRUARY 21, 1968 3:48 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.				
FEMALE			WHITE			1-27-86			82 YRS.			MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										
MARYLAND			U.S.A.						ALLEGANY Md.										
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life)				12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND				MEMORIAL				HOUSEWIFE											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
MD.				ALLEGANY		CUMBERLAND				446 N. CENTRE ST.									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last														
JOHN SCHLUND					MARY GORE														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address									
NO					214-30-9738B					MEMORIAL HOSPITAL, CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Older Myocardial Thrombosis</u> 4409 DUE TO, OR AS A CONSEQUENCE OF <u>9 angina & Spont. perforated bowel</u> (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
										24 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>5702 Acute Myocardial Infarction and congestive Heart Failure</u>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <u>2-20</u> , 19 <u>68</u> , to <u>2-21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-21-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>William R. James</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>2/23/68</u>									
22d. PHYSICIAN'S NAME (Type) <u>W. P. JAMES, M.D.</u>										22e. ADDRESS <u>441 N. CENTRE ST., CUMBERLAND, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)										
BURIAL			24 FEB 68			TRINITY LUTH. CEMETERY			CUMBERLAND ALLEGANY MD.										
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
H. LEE SILCOX 404 DECATUR ST. CUMBERLAND MD.										FEB 26 1968		<u>Charles Judge</u>							

01933

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CLARA	LOUISE	SIMONELA	FEBRUARY 21, 1988 3:58 PM
FEMALE	WHITE	1-27-88	02
MARYLAND	U.S.A.	ALLEANY	
CUMBERLAND	NEONATAL	ALLEANY CUMBERLAND X	100 N. CENTRE ST.

BORE	HARRY	NEONATAL HOSPITAL, CUMBERLAND, MD.
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W.F. JAMES, M.D.	100 N. CENTRE ST., CUMBERLAND, MD.
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